

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6177

CERTIFICATE OF DEATH

06166

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Pennsylvania</u> COUNTY <u>Lycoming</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort George G. Meade</u>		4 1/2 months		TOWN <u>Montgomery</u>		75 X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>32 W. Houston Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>WILLIAM</u> <u>EMERSON</u> <u>BANGHART</u>				July 9 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
Male	White	Single	9 July 1955			10 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None		None		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Emerson Banghart</u>				<u>Dawn Grace St. James</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
None		None		Father: <u>William Emerson Banghart</u> Hq. Co. 2101 ASD, Fort G.G. Meade, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Respiratory Failure - Atelectasis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs. 24 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
0							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9 July</u> , 19 <u>55</u> , to <u>9 July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9 July</u> , 19 <u>55</u> , and that death occurred at <u>1645</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Alfred E. Neale</u> <u>ALFRED E. NEALE, CAPT., MC</u>				ADDRESS (Street, city, town, state) <u>Fort G.G. Meade, Md.</u> DATE SIGNED <u>9 July 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12 July 1955</u>		<u>Post Cemetery</u>		<u>Fort G.G. Meade, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>11 July 1955</u>		<u>W. L. Saylor, 1st Lt MSC</u>		<u>Chaplain White</u>		<u>Fort G.G. Meade, Md.</u>	

2075221312

CERTIFICATE OF DEATH

Form 100-100

1. Name of deceased (Print or type)

2. Sex (M or F)

3. Date of birth (Month, day, year)

4. Place of birth (City, State, Country)

5. Date of death (Month, day, year)

6. Place of death (City, State, Country)

7. Cause of death (List all causes, beginning with the immediate cause)

8. Duration of illness (If applicable)

9. Signature of attending physician (Print name and sign)

10. Signature of registrar (Print name and sign)

11. Signature of informant (Print name and sign)

12. Signature of medical examiner (Print name and sign)

13. Signature of coroner (Print name and sign)

14. Signature of funeral director (Print name and sign)

15. Signature of undertaker (Print name and sign)

16. Signature of cemetery (Print name and sign)

17. Signature of burial place (Print name and sign)

18. Signature of interment place (Print name and sign)

19. Signature of crematorium (Print name and sign)

20. Signature of other (Print name and sign)

BUREAU V. E.

JUL 13 1955

RECEIVED

6173 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Balto.</u> CITY <u>city</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL OR and give nearest town)	
X TOWN <u>Glen Burnie</u>	<u>7 mo</u>	TOWN <u>Baltimore</u>	<u>3V01-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>309 Furnace Branch Rd</u>		<u>2029 E. Lanvale St.</u>	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First)	(Middle)	(Month)	(Day)
<u>HERMAN</u>	<u>(none)</u>	<u>July</u>	<u>28</u>
(Type or Print)		(Year)	
<u>BARRY</u>		<u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE MARRIED, WIDOWER, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>M</u>	<u>W</u>	<u>Married</u>	<u>Sept. 16, 1885</u>
			9. AGE last birthday <u>69</u> yrs.
			IF UNDER 1 YEAR IF UNDER 24 HRS.
			Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<u>Electrician</u>	<u>Mas & Elect. Co.</u>	<u>Chicago, Ill.</u>	<u>Yes - USA</u>

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
<u>John Barry (dec.)</u>	<u>Not known</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
<u>yes</u> (If Yes, give war or dates of service) <u>1905-1909</u>	<u>212-05-7362</u>	<u>Mrs. Claudia Barry (wife) 309 Furnace Branch Rd</u>

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Terminal pneumonia</u>		<u>1 day</u>
Antecedent causes (s) (b) <u>Cancer of lung</u>		<u>2 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Chronic bronchitis</u>		<u>20 yrs</u>
11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death. <u>arteriosclerosis, arthritis</u>		<u>20 yrs</u>

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY ?
<u>0 none</u>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
<u>none</u>				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR ?		
OF INJURY	While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from May 22, 1955, to present, 1955, that I last saw the deceased alive on July 14, 1955, and that death occurred at 7:45 A.M. from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
<u>H.F. Manuzak</u>	<u>M.D.</u>	<u>901 Edgerly Rd., Glen Burnie, Md.</u>	<u>July 28, 1955</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 30, 1955</u>	<u>Glen Haven Memorial Park</u>	<u>Glen Burnie, AA Co., Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>July 28, 1955</u>	<u>L. J. DeAlba</u>	<u>Hopping and Kirkley</u>	<u>Glen Burnie, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 8 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06168

6173

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10</u> TOWN <u>7</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shady Oaks</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u> <u>51</u> <u>Annapolis, Maryland</u>				STREET ADDRESS (If rural give location) <u>X</u> <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Baby Girl</u> <u>BERWICK</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July</u> <u>3</u> <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 3, 1955</u>	9. AGE last birthday yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Alexander (n) BERWICK</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth May Player</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Father: U.S. Naval Hospital</u> <u>Annapolis, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>761.5 Prematurity due to premature separation of</u>						INTERVAL BETWEEN ONSET AND DEATH <u>761.5</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Placenta</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) _____							
DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>7-3</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not white <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-3</u>, 19 <u>55</u>, to <u>7-3</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>7-3</u>, 19 <u>55</u>, and that death occurred at <u>0125a</u> M, from the causes and on the date stated above. SIGNATURE <u>E.R. PETERS LT MC USN</u> M.D. <u>U.S. Naval Hospital</u> DATE SIGNED <u>7-6-66</u> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		DATE THEREOF <u>7/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>NAVAL ACADEMY</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
24. REC'D BY REGISTRAR DATE <u>July 6, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M Taylor</u>		ADDRESS <u>Annapolis Md.</u>	

20751323281

10

2121

• 22 475-0303

3. 56

BUREAU V. S.

JUL 8 1955

RECEIVED

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

THE UNIVERSITY OF CHICAGO PRESS

06169

MARYLAND STATE DEPARTMENT OF HEALTH

6180

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

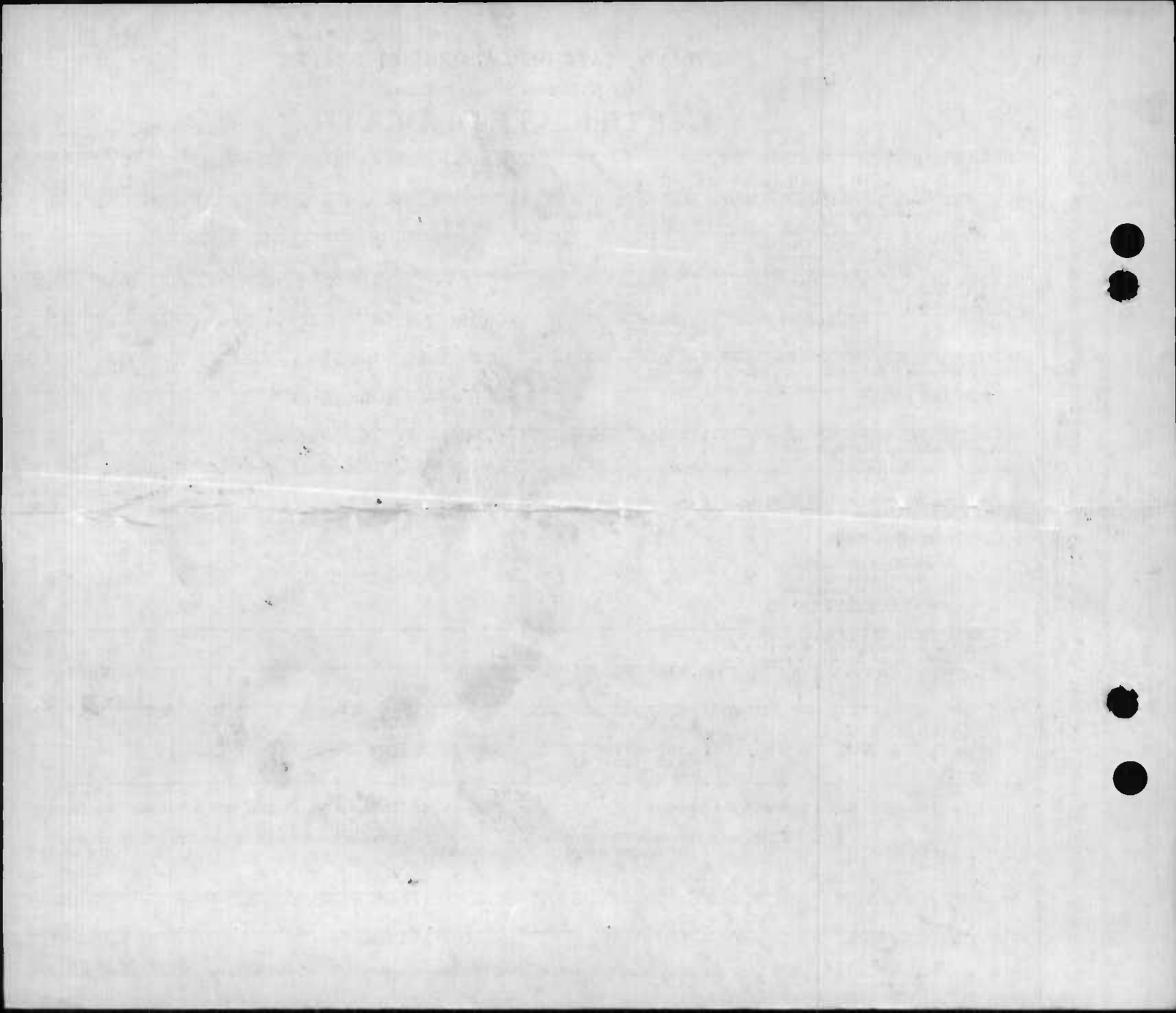
Reg. Dist. No. 21

1. PLACE OF DEATH - COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>One branch</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harman</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harman</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Perry Road</u>		STREET ADDRESS (If rural, give location) <u>Perry Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Sallie</u> (First) <u>M.</u> (Middle) <u>Blue</u> (Last)	4. DATE OF DEATH <u>July 5 - 55</u> (Month) (Day) (Year)		
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug. 1, 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cameron N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Bettie Nailer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Cecil Harrington - Harman</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
332X Immediate cause (a) <u>Cerebral Infarct</u>		<u>1 day</u>	
Antecedent cause(s) (b) <u>Generalized Arteriosclerosis</u>		<u>2 years</u>	
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) <u>July 5, 1955</u>		HOW DID INJURY OCCUR? <u>While at Work</u>	
22. I hereby certify that I attended the deceased from <u>July 3 - 55</u> , 19 <u>55</u> , and that death occurred at <u>1 P.</u> m., from the causes and on the date stated above.		DATE SIGNED <u>7-7-55</u>	
SIGNATURE <u>Dr. H. H. Schroeder</u>		ADDRESS <u>332X</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REG. <u>7-8-55</u>		24. FUNERAL DIRECTOR <u>Dr. H. H. Schroeder</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6181

CERTIFICATE OF DEATH

06120

Long Point R.F.D. #1 Crownsville Md Reg. Dist. No. *21*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>Maryland</i> COUNTY <i>Anne Arundel</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN		<i>D.O.A.</i>		TOWN <i>Crownsville, D.C.</i>		<i>47X3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<i>00</i>				<i>Long Point R.F.D. #1</i>			
<i>200 R.F.D. #1 N.E. 1</i>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<i>Robert M. Boardman</i>				<i>July 29 1955</i>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<i>MALE</i>		<i>W.</i>		<i>Married</i>		<i>July 14, 1888</i>	
						<i>67</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Clerk War Bureau U.S. Gov.</i>				<i>Washington D.C.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>unknown</i>				<i>unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
				<i>578-16-8912</i>		<i>Alfred F. Yates Washington D.C.</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<i>420.1</i>				<i>?</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<i>0</i>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7/29</i> , 19 <i>55</i> , to <i>7/29</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>7/29</i> , 19 <i>55</i> , and that death occurred at <i>7</i> M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>[Signature]</i>				<i>[Address]</i>		<i>7/29/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Removal</i>		<i>7-29-55</i>		<i>Rock Creek Cemetery</i>		<i>Washington, D.C.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>			
DATE		<i>8-3-1955</i>		<i>The S.H. Himes Co. Washington D.C.</i>			

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06171

6159 CERTIFICATE OF DEATH

Item 4, film 184 7-27-55 et

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>A.A.</u>	STATE <u>MARYLAND</u>	CITY <u>ANNAPOLIS</u>	COUNTY <u>A.A.</u>
CITY <u>ANNAPOLIS</u>	LENGTH OF STAY <u>10</u>	CITY <u>ANNAPOLIS</u>	CITY <u>ANNAPOLIS</u>
TOWN <u>ANNAPOLIS</u>	(In this place)	TOWN <u>ANNAPOLIS</u>	(If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ANNE ARUNDEL GENERAL</u>	STREET ADDRESS <u>23 FRANCIS ST.</u>		
3. NAME OF DECEASED		4. DATE OF DEATH	
(Type or Print) <u>EFFIE</u>	(First) <u>BOUNEKIS</u> (Last)	(Month) <u>July</u>	(Day) <u>20</u> (Year) <u>1955</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Nov. 30, 1902</u>
9. AGE last birthday <u>53</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>TURKEY</u>
13. FATHER'S NAME <u>ANGELO KOSMIDES</u>		14. MOTHER'S MAIDEN NAME <u>ATHENA KARIDES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>#2</u>	
17. INFORMANT & ADDRESS <u>ANGEL BOUNEKIS</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<u>174X IMMEDIATE CAUSE (A) <u>Coccarixia -</u></u>		<u>2 mos.</u>	
<u>ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA UTERUS, EXTENSIVE</u></u>		<u>5-6 mos</u>	
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>+ METASTATIC</u></u>		<u>2 mos</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>FECAL FISTULA, UAGINA, ABDOMINAL</u>		<u>2 mos</u>	
19a. DATE OF OPERATION <u>4/18/55</u>	19b. MAJOR FINDINGS OF OPERATION <u>ADVANCED EPIDERMAL CARCINOMA UTERUS</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 1955</u>, to <u>July 20, 55</u>, that I last saw the deceased alive on <u>July 20, 55</u>, and that death occurred at <u>6:45 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Dr. Christopher J. Frankel</u>		DATE SIGNED <u>7/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. DATE <u>7/22/55</u>	
DATE THEREOF <u>7/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>ST. MARGARET'S</u>	
LOCATION (City, town, or county) (State) <u>ST. MARGARET'S</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Tytor</u>	
24. REC'D BY REGISTRAR <u>7/22/55</u>		25. ADDRESS <u>St. Annapolis, Md.</u>	

DEATH CERTIFICATE

This certificate is to be filled out by the physician or other qualified person who attended the deceased during his or her last illness. It should be filled out as soon as possible after death, and it should be signed by the physician or other qualified person who attended the deceased during his or her last illness. It should be filed in the office of the Registrar of Births and Deaths, and it should be made available to the public upon request.

DEATH CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

BUREAU V.

JUL 25 1935

RECEIVED

6182

06172

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 28

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
<input checked="" type="checkbox"/> TOWN <u>Crownsville</u>		<u>2 yrs</u>		TOWN <u>Crownsville</u>		<u>Box 438 B</u> <input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Old River Rd.</u>				STREET ADDRESS (If rural, give location) <u>Old River Rd.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>RAY</u>		(Middle) <u>ELSWORTH</u>		(Last) <u>BRICE</u>		(Month) <u>JULY</u>	
(Day) <u>10</u>		(Year) <u>19 55</u>					
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Single</u>		<u>May 24, 1955</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		9b. KIND OF BUSINESS OR INDUSTRY:		10. BIRTHPLACE (State or foreign country):		11. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>none</u>		<u>Baltimore, Maryland</u>		<u>USA</u>	
12. FATHER'S NAME:				13. MOTHER'S MAIDEN NAME:			
<u>Charles Elsworth Brice</u>				<u>Irene B. Aughinbaugh</u>			
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				15. SOCIAL SECURITY No.:		16. INFORMANT & ADDRESS:	
<u>---</u>				<u>---</u>		<u>Mr Charles E. Brice- Father- same as # 2</u>	

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						sudden	
<p><u>491X</u></p> <p>Immediate cause (a) <u>Aspiration Pneumonia</u></p> <p style="text-align: center;">DUE TO</p> <p>Antecedent cause(s) (b)</p> <p>Diseases or conditions, if any, giving rise to the above cause (c)</p> <p>stating <u>underlying cause last</u></p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<u>0</u>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
				<u>Crownsville Anne Arundel Maryland</u>		<u>Natural Causes</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>July 10, 55</u>		<u>a m</u>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from <u>Natural causes</u> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.			
<u>Elmer G. Linhardt</u>				<u>July 10, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 11, 55</u>		<u>Cedar Bluff Cemetery</u>		<u>Annapolis, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>11-12-55</u>		<u>K M</u>		<u>Ben L. Hopping and Son</u>		<u>Annapolis, Md.</u>	

2055351395

MEMORANDUM FOR THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

DATE: [Illegible]

REFERENCE: [Illegible]

DETAILS: [Illegible]

CONCLUSION: [Illegible]

RECOMMENDATION: [Illegible]

ADMINISTRATIVE: [Illegible]

OTHER: [Illegible]

APPROVAL: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

REMARKS: [Illegible]

ENCLOSURES: [Illegible]

COPIES: [Illegible]

FILE: [Illegible]

NOTES: [Illegible]

BUREAU V. 3

RECEIVED

Jul 18 1961

[Handwritten signature]

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6183

CERTIFICATE OF DEATH

06173

Reg. Dist. No. 28

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>6 mos. 19 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rockville</u>		<u>15-26-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 167</u>			
3. NAME OF DECEASED (Type or Print) <u>Joseph Brightful</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7 1 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Sep.</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>Over 70</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper in Nursery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William Brightful</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Brightful</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>218-30-4062</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Decompensatory heart failure</u>						Since adm. <u>1/12/55</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/12</u> , 19 <u>55</u> , to <u>7/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/1</u> , 19 <u>55</u> , and that death occurred at <u>7:10a</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		(L. Benedict)		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>7/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/4/55</u>		NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>Union Bridge Md</u>	
24. REC'D BY REGISTRAR <u>7-1-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Snowden</u>		ADDRESS <u>Rockville, Md</u>	

CERTIFICATE OF DEATH

LOCAL RESIDENCE PRIOR TO DECEASE

PLACE OF BIRTH

DATE OF DEATH
1955
MAY 10
TIME OF DEATH
10:00 AM

MARRIED
SINGLE
WIDOW
DIVORCED

AGE
35
SEX
MALE

PLACE OF DEATH
HOME
HOSPITAL
NURSING HOME
OTHER

CAUSE OF DEATH
HEART DISEASE
CORONARY ARTERY DISEASE
MURDER
SUICIDE
OTHER

PLACE OF BIRTH
BALTIMORE
MARYLAND
OTHER

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

DATE OF BIRTH
1920
PLACE OF BIRTH
BALTIMORE
MARYLAND

BUREAU V. S.

MAY 7 1955

RECEIVED

(1. Immediate)

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT. IT IS TO BE DESTROYED AFTER FIFTY YEARS.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

06174

6160

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>C. A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 10		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 10	
OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		STREET ADDRESS <u>110 St. Washington St.</u>		STREET ADDRESS <u>110 St. Washington St.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>110 St. Washington St.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Baby</u> (Middle) <u>Brown</u> (Last)				4. DATE OF DEATH (Month) <u>7</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. SINGLE, MARRIED, WIDDED, DIVORCED, (Specify) <u>S.</u>		8. DATE OF BIRTH <u>7-8-1955</u>	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
yrs. <u>6</u>		Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u>		yrs. <u>6</u>		Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u>	
13. FATHER'S NAME <u>Alvin Brown</u>				14. MOTHER'S MAIDEN NAME <u>Carrie M. Savoy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT & ADDRESS <u>Carrie M. Savoy Annapolis</u>							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
754.4 IMMEDIATE CAUSE (A) <u>Congenital Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/8/55</u> , 19 <u>55</u> , to <u>7/14/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/14/55</u> , 19 <u>55</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thodore H. Johnson</u>		DATE SIGNED <u>7/15/55</u>		ADDRESS (Street, city, town, state) <u>3 Robert St., Annapolis, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7-16-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Ann's</u>		LOCATION (City, town, of county) (State) <u>Annapolis, Md.</u>	
24. REC'D BY REGISTRAR <u>July 15</u>		REGISTRAR'S SIGNATURE <u>J. J. O'Connell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		ADDRESS <u>Annapolis, Md.</u>	

1075172382

[Faint handwritten notes, possibly bleed-through from the reverse side.]

7-2-57

BUREAU V. S.

JUL 18 1955

1815
 1816
 1817
 1818
 1819
 1820
 1821
 1822
 1823
 1824
 1825
 1826
 1827
 1828
 1829
 1830
 1831
 1832
 1833
 1834
 1835
 1836
 1837
 1838
 1839
 1840
 1841
 1842
 1843
 1844
 1845
 1846
 1847
 1848
 1849
 1850
 1851
 1852
 1853
 1854
 1855
 1856
 1857
 1858
 1859
 1860
 1861
 1862
 1863
 1864
 1865
 1866
 1867
 1868
 1869
 1870
 1871
 1872
 1873
 1874
 1875
 1876
 1877
 1878
 1879
 1880
 1881
 1882
 1883
 1884
 1885
 1886
 1887
 1888
 1889
 1890
 1891
 1892
 1893
 1894
 1895
 1896
 1897
 1898
 1899
 1900

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS-15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06175

6161

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u> MARYLAND		STATE <u>Md.</u> COUNTY <u>AA</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		OR TOWN <u>Edgewater PO</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS <u>Mayo, Md.</u>			
3. NAME OF DECEASED (Type or Print) <u>Margaret Rosella Bull</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 25</u> 19 <u>55</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>October 19, 1865</u>	
9. AGE last birthday <u>89</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Shadyside, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>			
13. FATHER'S NAME <u>John Popham</u>				14. MOTHER'S MAIDEN NAME <u>Priscilla Westerman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS <u>Mrs Harvey Cummings, Mayo, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Senility</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2.3 mos</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Fracture hip left</u>				4 dys			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>Cardiac failure</u>				1 dy			
STATING UNDERLYING CAUSE LAST. (C) <u>Dehydration</u>				?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>7-22-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Simple intertrochanteric fracture</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) <u>Anne Arundel Co. Md</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Fell in home</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input checked="" type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell in home</u>			
22. I hereby certify that I attended the deceased from <u>July 21, 1955</u> , to <u>July 25, 1955</u> , that I last saw the deceased alive on <u>July 24, 1955</u> , and that death occurred at <u>3:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Harold R. Bohleman M.D.</u>				ADDRESS (Street, city, town, state) <u>916 Cathedral St. Annapolis, Md.</u>			
DATE <u>July 26, 1955</u>				DATE SIGNED <u>July 26, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 27, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mayo Memorial Church</u>		LOCATION (City, town, or county) (State) <u>Mayo, Edgewater PO, Md.</u>	
24. REG'D. REGISTRAR <u>V. J. Smith</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Stibler</u>		ADDRESS <u>Hopping Funeral Home, Annapolis, Md.</u>	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

SEX

AGE

SEX

SEX

SEX

SEX

SEX

SEX

SEX

BUREAU V. A.

JUL 29 1955

RECEIVED

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A155 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06176

6184

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY <u>Anna Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>_____</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN <u>Baltimore</u>	
TOWN <u>Fort George G. Meade</u>				STREET ADDRESS (If rural give location)		<u>3908 Beech Avenue</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>WILLIAM</u> <u>Winden</u> <u>BURKE</u>				<u>July</u> <u>23</u> <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 3, 1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Burke</u>				14. MOTHER'S MAIDEN NAME <u>Nellie - Henricks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>460-01-8258</u>		17. INFORMANT & ADDRESS <u>Wife Mrs. Josephine Burke, 3908 Beech Ave,</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial infarction.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>6:35 AM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>22 July, 19 55</u> to <u>23 July, 19 55</u> , that I last saw the deceased alive on <u>23 July, 19 55</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Herbert L. Needelman, Lt. MC</u>				ADDRESS (Street, city, town, state) <u>M.D. Fort George G. Meade, Md.</u>			
DATE <u>23 July 1955</u>				DATE SIGNED <u>23 July 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-26-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		LOCATION (City, town, or county) <u>Bel Air, Baltimore, Virginia</u>	
24. REC'D BY REGISTRAR <u>WILLIAM L. SAYLOR, 1ST LT MSC</u>		REGISTRAR'S SIGNATURE <u>William L. Saylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK & BLIGHT INC</u>		ADDRESS <u>Baltimore, Md</u>	
DATE <u>23 July 1955</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

RESIDENCE

DECEASED

BUREAU V. S.

JUL 20 1955

RECEIVED

100-100000-100000

100-100000-100000

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

06177

Reg. Dist. No.

6185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MD.</u> COUNTY <u>A. A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		LENGTH OF STAY (in this place) <u>4 yrs.</u>		TOWN <u>Severna Park</u>		TOWN <u>Severna Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CYPRESS CREEK</u>				STREET ADDRESS (If rural give location) <u>Cypress Creek Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>James Franklin Christopher</u>				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>20</u> (Year) <u>1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Feb. 7, 1921</u>	
9. AGE last birthday <u>34</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fuel oil</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Robert E. Christopher</u>		14. MOTHER'S MAIDEN NAME <u>Cora Foor</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u> (If Yes, give year or dates of service) <u>1943-43</u>	
16. SOCIAL SECURITY NO. <u>173-14-3191</u>		17. INFORMANT & ADDRESS <u>wife Cypress Creek Rd. Severna Park</u>		18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.1 IMMEDIATE CAUSE (A) : <u>Respiratory and circulatory failure</u>				<u>30 min</u>			
ANTECEDENT CAUSE(S) DUE TO (B) : <u>Myocardial infarction</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) :							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>20 July, 1955</u> , to <u>20 July, 1955</u> , that I last saw the deceased alive on <u>20 July, 1955</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. De Alba</u>		ADDRESS (Street, city, town, state) <u>Severna Park Md</u>		DATE SIGNED <u>20 July 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>July 23, 55</u>		NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		LOCATION (City, town, or county) (State) <u>BLADENSBURG MD</u>	
24. REC'D BY REGISTRAR <u>July 23, 1955</u>		REGISTRAR'S SIGNATURE <u>R. De Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>How Burnice</u>		ADDRESS <u>Severna Park</u>	

10

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06178

6183

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>West</u> TOWN <u>Sudley River P.O.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>A.A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sudley, West River P.O.</u> TOWN <u>Sudley, West River</u> STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Thomas Clyde Collinson</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>July 14</u> 19 <u>55</u> (Month) (Day) (Year)			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 13</u> 189 <u>3</u> yrs.	9. AGE last birthday <u>62</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		11. BIRTHPLACE (State or foreign country) <u>Deale, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas W. Collinson</u>				14. MOTHER'S MAIDEN NAME <u>Berenia Franklin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Francis Bagby Collinson</u> <u>West River, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
154X IMMEDIATE CAUSE (A) <u>Cardiac Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Few hours</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Infection</u>				<u>one month</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO <u>Adenocarcinoma of Rectum</u>				<u>2 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Oct '54</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of rectum</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 19, 35</u> , to <u>July 14, 55</u> , that I last saw the deceased alive on <u>13 July</u> , 19 <u>55</u> , and that death occurred at <u>8:15 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>T. A. Shady Side</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>7-14-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		LOCATION (City, town, or county) (State) <u>Friendship, Md.</u>	
24. REC'D BY REGISTRAR <u>Edw. W. Williams</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>T. A. Shady Side</u>		ADDRESS <u>Shady Side</u>	
DATE <u>7/16/55</u>							

REPORT OF DEATH

This report is to be filled out by the physician or other qualified person who attended the deceased during his or her last illness. It should be filled out as soon as possible after death, and it should be filed with the local health department or the Bureau of Health Statistics, State of Maryland, as soon as possible after death. The report should be filled out in ink, and it should be signed by the reporting physician or other qualified person. The report should be filled out in the English language, and it should be filled out in the metric system. The report should be filled out in the following manner:

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Page No. 1

1. PLACE OF DEATH

2. USUAL RESIDENCE OF DECEASED

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. MEDICAL EXAMINATION

BUREAU V. 2

JUL 28 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06179

6162

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>				OR TOWN <u>North Severn</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>34 Eucalyptus Rd.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Baby Boy COX				July 17 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	Cau		7-17-55	ys.	Months	Days	Hours Min.
							2 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Md		US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Roy E COX				Grace Julia PATOSKEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				USNH Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
776X IMMEDIATE CAUSE (A) <u>Immaturity due to Premature Labor</u>						INTERVAL BETWEEN ONSET AND DEATH <u>776</u>	
DUE TO ANTECEDENT CAUSE(S) (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C)							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7-17-55, to 7-17-55, that I last saw the deceased alive on 7-17-55, and that death occurred at 3:17 PM, from the causes and on the date stated above.							
SIGNATURE <u>J.C. Hodges</u>				ADDRESS (Street, city, town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u>		DATE SIGNED <u>7-17-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-18-55		Naval Academy		Annapolis, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>7-19-55</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>Annapolis, Md.</u>	

2075276220

CERTIFICATE OF DEATH

1. NAME OF DECEASED

WESTLAND

2. PLACE OF DEATH

BALTIMORE

3. DATE OF DEATH

1955

4. TIME OF DEATH

10:00 AM

5. CAUSE OF DEATH

HEART DISEASE

6. PLACE OF BIRTH

BALTIMORE

7. SEX

MALE

8. AGE

45

9. OCCUPATION

CLERK

10. MARITAL STATUS

MARRIED

11. EDUCATION

HIGH SCHOOL

12. RELIGION

ROMAN CATHOLIC

13. SIGNATURE OF DECEASED

[Signature]

14. SIGNATURE OF WITNESSES

[Signature]

15. SIGNATURE OF PHYSICIAN

[Signature]

16. SIGNATURE OF CORONER

[Signature]

17. SIGNATURE OF JURY

[Signature]

18. SIGNATURE OF JUDGE

[Signature]

19. SIGNATURE OF CLERK

[Signature]

20. SIGNATURE OF REGISTRAR

[Signature]

21. SIGNATURE OF DECEASED

[Signature]

22. SIGNATURE OF WITNESSES

[Signature]

23. SIGNATURE OF PHYSICIAN

[Signature]

24. SIGNATURE OF CORONER

[Signature]

25. SIGNATURE OF JURY

[Signature]

26. SIGNATURE OF JUDGE

[Signature]

27. SIGNATURE OF CLERK

[Signature]

28. SIGNATURE OF REGISTRAR

[Signature]

29. SIGNATURE OF DECEASED

[Signature]

30. SIGNATURE OF WITNESSES

[Signature]

31. SIGNATURE OF PHYSICIAN

[Signature]

32. SIGNATURE OF CORONER

[Signature]

33. SIGNATURE OF JURY

[Signature]

34. SIGNATURE OF JUDGE

[Signature]

35. SIGNATURE OF CLERK

[Signature]

36. SIGNATURE OF REGISTRAR

[Signature]

37. SIGNATURE OF DECEASED

[Signature]

38. SIGNATURE OF WITNESSES

[Signature]

39. SIGNATURE OF PHYSICIAN

[Signature]

40. SIGNATURE OF CORONER

[Signature]

41. SIGNATURE OF JURY

[Signature]

42. SIGNATURE OF JUDGE

[Signature]

43. SIGNATURE OF CLERK

[Signature]

44. SIGNATURE OF REGISTRAR

[Signature]

45. SIGNATURE OF DECEASED

[Signature]

46. SIGNATURE OF WITNESSES

[Signature]

47. SIGNATURE OF PHYSICIAN

[Signature]

48. SIGNATURE OF CORONER

[Signature]

49. SIGNATURE OF JURY

[Signature]

50. SIGNATURE OF JUDGE

[Signature]

51. SIGNATURE OF CLERK

[Signature]

52. SIGNATURE OF REGISTRAR

[Signature]

53. SIGNATURE OF DECEASED

[Signature]

54. SIGNATURE OF WITNESSES

[Signature]

55. SIGNATURE OF PHYSICIAN

[Signature]

56. SIGNATURE OF CORONER

[Signature]

57. SIGNATURE OF JURY

[Signature]

58. SIGNATURE OF JUDGE

[Signature]

59. SIGNATURE OF CLERK

[Signature]

60. SIGNATURE OF REGISTRAR

[Signature]

61. SIGNATURE OF DECEASED

[Signature]

62. SIGNATURE OF WITNESSES

[Signature]

63. SIGNATURE OF PHYSICIAN

[Signature]

64. SIGNATURE OF CORONER

[Signature]

65. SIGNATURE OF JURY

[Signature]

66. SIGNATURE OF JUDGE

[Signature]

67. SIGNATURE OF CLERK

[Signature]

68. SIGNATURE OF REGISTRAR

[Signature]

69. SIGNATURE OF DECEASED

[Signature]

70. SIGNATURE OF WITNESSES

[Signature]

71. SIGNATURE OF PHYSICIAN

[Signature]

72. SIGNATURE OF CORONER

[Signature]

73. SIGNATURE OF JURY

[Signature]

74. SIGNATURE OF JUDGE

[Signature]

75. SIGNATURE OF CLERK

[Signature]

76. SIGNATURE OF REGISTRAR

[Signature]

77. SIGNATURE OF DECEASED

[Signature]

78. SIGNATURE OF WITNESSES

[Signature]

79. SIGNATURE OF PHYSICIAN

[Signature]

80. SIGNATURE OF CORONER

[Signature]

81. SIGNATURE OF JURY

[Signature]

82. SIGNATURE OF JUDGE

[Signature]

83. SIGNATURE OF CLERK

[Signature]

84. SIGNATURE OF REGISTRAR

[Signature]

85. SIGNATURE OF DECEASED

[Signature]

86. SIGNATURE OF WITNESSES

[Signature]

87. SIGNATURE OF PHYSICIAN

[Signature]

88. SIGNATURE OF CORONER

[Signature]

89. SIGNATURE OF JURY

[Signature]

90. SIGNATURE OF JUDGE

[Signature]

91. SIGNATURE OF CLERK

[Signature]

92. SIGNATURE OF REGISTRAR

[Signature]

93. SIGNATURE OF DECEASED

[Signature]

94. SIGNATURE OF WITNESSES

[Signature]

95. SIGNATURE OF PHYSICIAN

[Signature]

96. SIGNATURE OF CORONER

[Signature]

97. SIGNATURE OF JURY

[Signature]

98. SIGNATURE OF JUDGE

[Signature]

99. SIGNATURE OF CLERK

[Signature]

100. SIGNATURE OF REGISTRAR

[Signature]

101. SIGNATURE OF DECEASED

[Signature]

102. SIGNATURE OF WITNESSES

[Signature]

103. SIGNATURE OF PHYSICIAN

[Signature]

104. SIGNATURE OF CORONER

[Signature]

105. SIGNATURE OF JURY

[Signature]

106. SIGNATURE OF JUDGE

[Signature]

107. SIGNATURE OF CLERK

[Signature]

108. SIGNATURE OF REGISTRAR

[Signature]

109. SIGNATURE OF DECEASED

[Signature]

110. SIGNATURE OF WITNESSES

[Signature]

111. SIGNATURE OF PHYSICIAN

[Signature]

112. SIGNATURE OF CORONER

[Signature]

113. SIGNATURE OF JURY

[Signature]

114. SIGNATURE OF JUDGE

[Signature]

115. SIGNATURE OF CLERK

[Signature]

116. SIGNATURE OF REGISTRAR

[Signature]

117. SIGNATURE OF DECEASED

[Signature]

118. SIGNATURE OF WITNESSES

[Signature]

119. SIGNATURE OF PHYSICIAN

[Signature]

120. SIGNATURE OF CORONER

[Signature]

121. SIGNATURE OF JURY

[Signature]

122. SIGNATURE OF JUDGE

[Signature]

123. SIGNATURE OF CLERK

[Signature]

124. SIGNATURE OF REGISTRAR

[Signature]

125. SIGNATURE OF DECEASED

[Signature]

126. SIGNATURE OF WITNESSES

[Signature]

127. SIGNATURE OF PHYSICIAN

[Signature]

128. SIGNATURE OF CORONER

[Signature]

129. SIGNATURE OF JURY

[Signature]

130. SIGNATURE OF JUDGE

[Signature]

131. SIGNATURE OF CLERK

[Signature]

132. SIGNATURE OF REGISTRAR

[Signature]

133. SIGNATURE OF DECEASED

[Signature]

134. SIGNATURE OF WITNESSES

[Signature]

135. SIGNATURE OF PHYSICIAN

[Signature]

136. SIGNATURE OF CORONER

[Signature]

137. SIGNATURE OF JURY

[Signature]

138. SIGNATURE OF JUDGE

[Signature]

139. SIGNATURE OF CLERK

[Signature]

140. SIGNATURE OF REGISTRAR

[Signature]

141. SIGNATURE OF DECEASED

[Signature]

142. SIGNATURE OF WITNESSES

6163

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Anne Arundel	MARYLAND	STATE Md.	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	3V01-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel Gen. Hosp.		STREET ADDRESS 718 Lyndhurst St.	✓
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH: July 21, 1955	
(First) ESTELLA	(Middle) R.	(Last) DASHIELL	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Jan. 28, 1874
9. AGE last birthday 81 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife		10B. KIND OF BUSINESS OR INDUSTRY: at home	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Wm. Bowen		14. MOTHER'S MAIDEN NAME: Mollie Wilhelm	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT & ADDRESS: Mrs. Charles Eackeles-718 Lyndhurst St.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) 422.1 Cerebral hemorrhage	DUE TO	8 days
ANTECEDENT CAUSE (B) Arteriosclerotic C. V. disease	DUE TO	yes.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (260X) d	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. diabetes mellitus		?

19A. DATE OF OPERATION: 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
----------------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

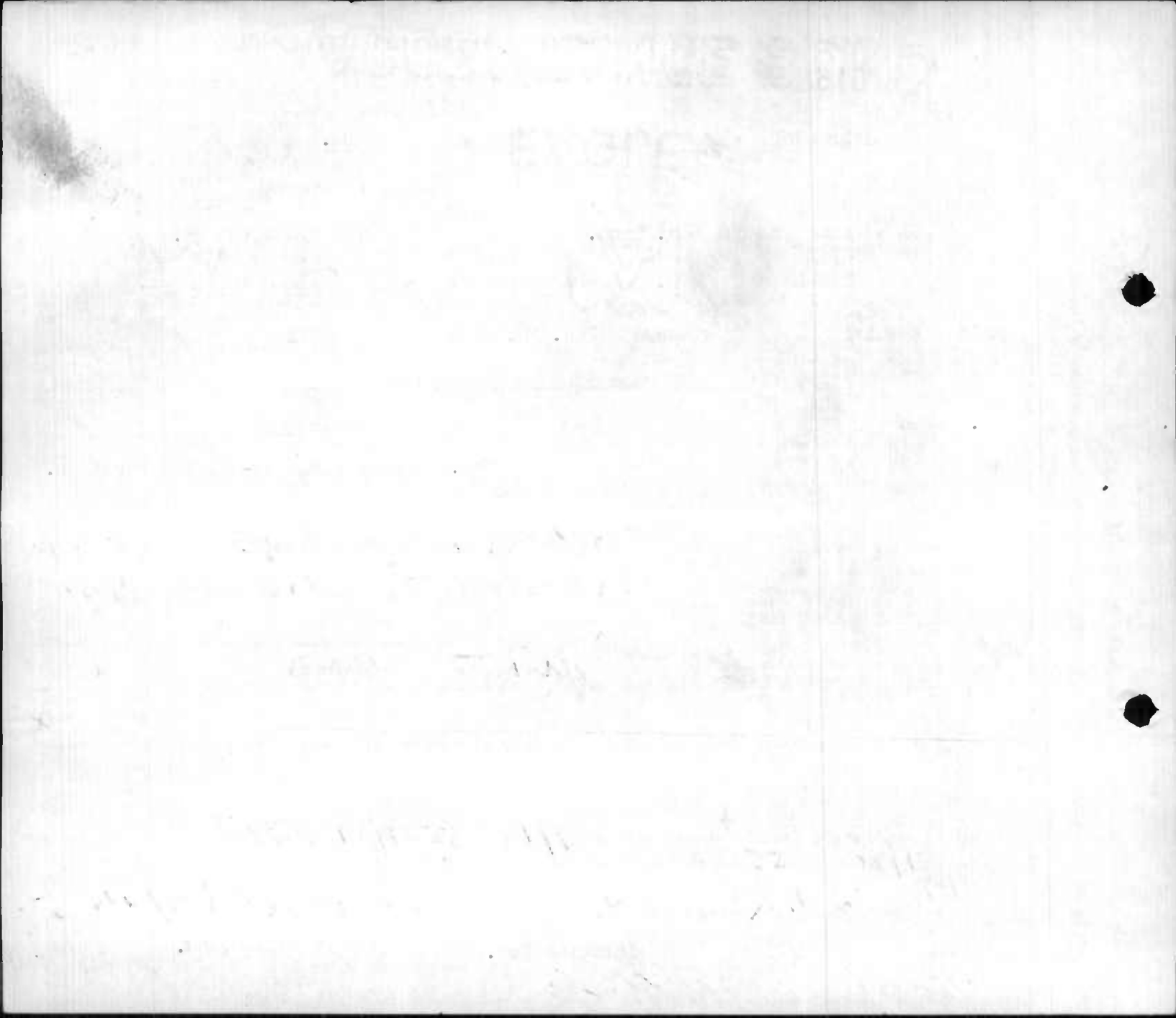
22. I hereby certify that I attended the deceased from **7/13, 1955** to **7/21, 1955** that I last saw the deceased alive on **7/20, 1955**, and that death occurred at **M.** from the causes and on the date stated above.

SIGNATURE Maurice F. Klawans	ADDRESS Annapolis, Md.	DATE SIGNED 7/24/55
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 7/23/55	NAME OF CEMETERY OR CREMATORY Lorraine Cem.
		LOCATION (City, town, or county) Woodlawn, Md.

DATE REC'D BY LOCAL REGISTRAR 7/22/55	REGISTRAR'S SIGNATURE A. W. Heald	FUNERAL DIRECTOR Wm. J. Tichenor & Sons - North & Pa. Aves
--	--	---

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6187				06181			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				Reg. Dist.			
Items 18&22 Film G185 9-1-55 ans				No. 24			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Severna Park</u>				TOWN <u>Crownsville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>Waterbury, P.O.</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print)		<u>CHARLES EDWARD DIGGS</u>		<u>7 8 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Colored</u>	<u>Single</u>	<u>8/7/35</u>	<u>19</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>laborer</u>				<u>Waterbury, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>David Diggs</u>				<u>Gertrude Pauline Hall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>no</u>				<u>David Diggs, (father)</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>936.9</u> Immediate cause (a) <u>Traumatic injuries of abdomen</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
				<u>AA</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
				<u>No indication of any beating</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>William J. Reese</u>		<u>7-10-55</u>		<u>John Wesley</u>		<u>Waterbury, Md</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Burial</u>		<u>L. J. DeAlba</u>		<u>William Reese, 11-108 St. Shafter</u>		<u>Annapolis, Md.</u>	
DATE REC'D BY LOCAL REG.							
<u>July 12, 1955</u>							

BUREAU V. 2

JUL 15 1955

RECEIVED

VS. A15-10-53

CERTIFICATE OF DEATH

State of _____ County of _____

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		Physician's Name	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner	
Date of Certificate		Time of Death		Place of Death		Signature of Burial Officer	
Signature of Undertaker		Signature of Funeral Home		Signature of Cemetery		Signature of Interment	
Signature of Health Officer		Signature of County Clerk		Signature of State Registrar		Signature of Federal Registrar	

MARYLAND STATE DEPARTMENT OF HEALTH

06183

6183

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH - COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
TOWN <u>Glen Burnie</u>		TOWN <u>Glen Burnie</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Oakwood Rd.</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>William</u> (Middle) <u>Marcion</u> (Last) <u>Ebberts, SR.</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>4</u> (Year) <u>1955</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9/24/91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metal work - at Huntington</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Huntington</u>	9. AGE last birthday <u>63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edw. Ebberts</u>		14. MOTHER'S MAIDEN NAME <u>Leontine Schaffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-09-0657</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Sylvia Ebberts (wife)</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) <u>Coronary Occlusion</u>		<u>Autopsy</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Walter A. Paulsen M.D.</u> (Degree or title)		ADDRESS <u>Glen Burnie, Md.</u> DATE SIGNED <u>7/4/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>July 7, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>	LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>
DATE REC'D BY LOCAL REG. <u>July 6, 1955</u>	REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>	24. FUNERAL DIRECTOR <u>Hopping and Kirkley, Glen Burnie, Md.</u> ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 8 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

6190

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH- COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Green Haven, Pasadena		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Stoney Creek		STREET ADDRESS (If rural, give location) 342 S. Calhoun St.	
3. NAME OF DECEASED (Type or Print) William F. Eichner		4. DATE OF DEATH July 23rd. 1955	
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated	8. DATE OF BIRTH 6/3/19
9. AGE last birthday 36 yrs.		10. If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mason		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) ? Balto Md.		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME Matthew Eichner		14. MOTHER'S MAIDEN NAME ? Louise Phalzer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Navy		16. SOCIAL SECURITY NO.	
17. INFORMANT Harriett and Peggy Eichner (daughters)			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
929.8 Accidental Drowning Immediate cause (a) Sudden		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office bldg.) OF INJURY Stoney Creek	(CITY OR TOWN) Green Haven (COUNTY) A.A. (STATE) Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY 7/23/55 5 P. m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Drowning

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

Deputy Medical Examiner

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

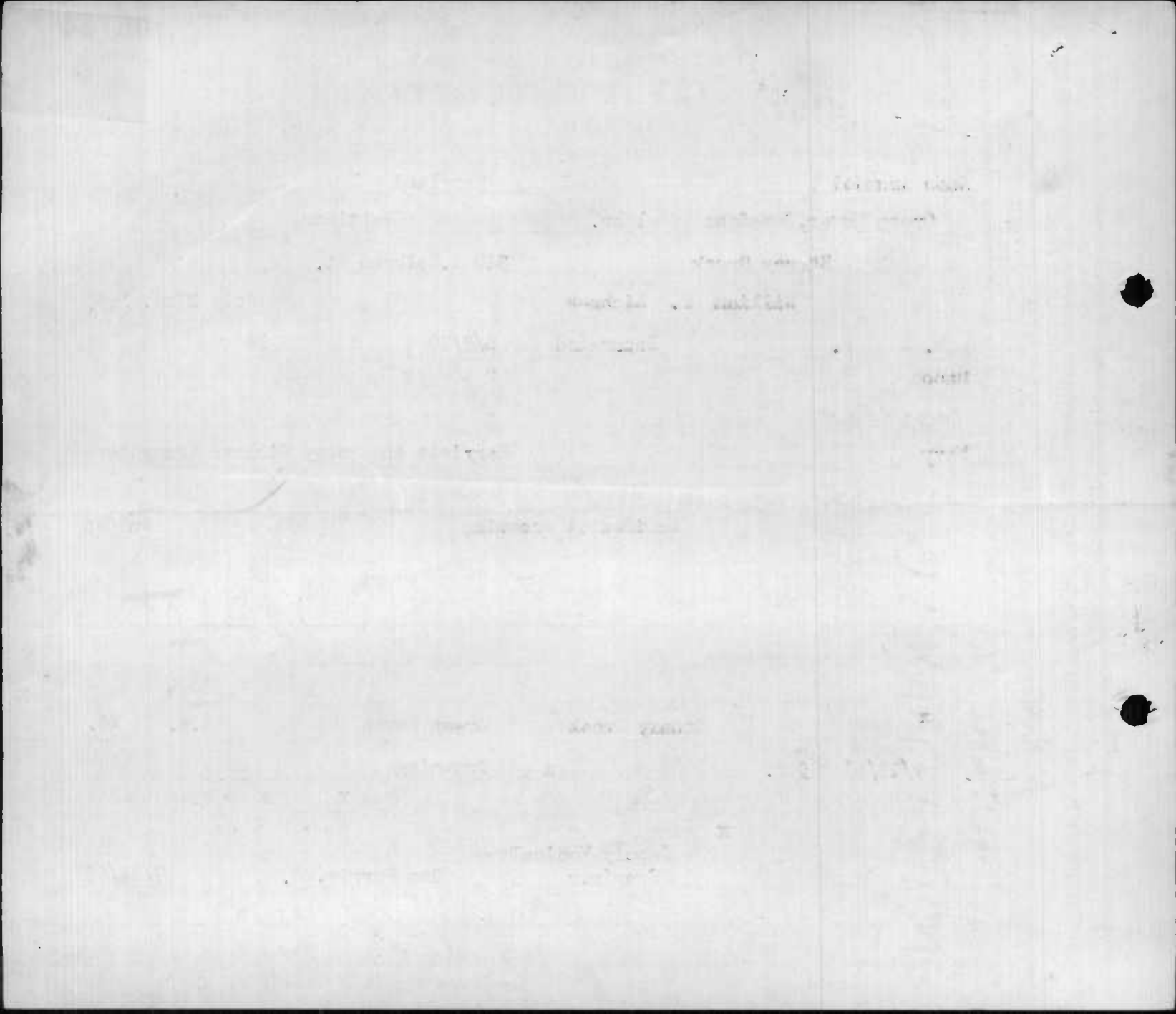
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 455-1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06185

CERTIFICATE OF DEATH

6164

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>105 CONDUIT ST</u>				STREET ADDRESS (If rural give location) <u>105 CONDUIT ST</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>JOHN C. FLOOD</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7-8-55</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>MARRIED</u>	8. DATE OF BIRTH <u>6-12-1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N.A.</u>		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN B. FLOOD</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes World War I</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>LILLIAN MYERS FLOOD</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1 IMMEDIATE CAUSE (A) <u>420.1</u>				<u>Coronary Thrombosis</u>		<u>0</u>	
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>Coronary Thrombosis</u>		<u>1 month</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I Hereby certify that I attended the deceased from <u>July 7, 1955</u>, to <u>July 8, 1955</u>, that I last saw the deceased alive on <u>July 7, 1955</u>, and that death occurred at <u>3:35 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>John R. Smith</u>				ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>		DATE SIGNED <u>7-8-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>Annapolis Md.</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
24. REC'D BY REGISTRAR <u>John M. Taylor</u>		REGISTRAR'S SIGNATURE <u>John M. Taylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Annapolis Md.</u>	
DATE <u>July 11, 1955</u>							

CERTIFICATE OF DEATH

Form 10-55-1

1. DECEASED'S FULL NAME AND LAST NAME

2. DATE OF BIRTH

3. SEX

4. RACE

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF CLERK

18. SIGNATURE OF NOTARY

19. SIGNATURE OF REGISTRAR

20. SIGNATURE OF DECEASED'S NEAREST RELATIVE

21. SIGNATURE OF DECEASED'S NEAREST RELATIVE

22. SIGNATURE OF DECEASED'S NEAREST RELATIVE

23. SIGNATURE OF DECEASED'S NEAREST RELATIVE

24. SIGNATURE OF DECEASED'S NEAREST RELATIVE

25. SIGNATURE OF DECEASED'S NEAREST RELATIVE

26. SIGNATURE OF DECEASED'S NEAREST RELATIVE

27. SIGNATURE OF DECEASED'S NEAREST RELATIVE

28. SIGNATURE OF DECEASED'S NEAREST RELATIVE

29. SIGNATURE OF DECEASED'S NEAREST RELATIVE

30. SIGNATURE OF DECEASED'S NEAREST RELATIVE

31. SIGNATURE OF DECEASED'S NEAREST RELATIVE

32. SIGNATURE OF DECEASED'S NEAREST RELATIVE

33. SIGNATURE OF DECEASED'S NEAREST RELATIVE

34. SIGNATURE OF DECEASED'S NEAREST RELATIVE

35. SIGNATURE OF DECEASED'S NEAREST RELATIVE

36. SIGNATURE OF DECEASED'S NEAREST RELATIVE

37. SIGNATURE OF DECEASED'S NEAREST RELATIVE

38. SIGNATURE OF DECEASED'S NEAREST RELATIVE

39. SIGNATURE OF DECEASED'S NEAREST RELATIVE

40. SIGNATURE OF DECEASED'S NEAREST RELATIVE

41. SIGNATURE OF DECEASED'S NEAREST RELATIVE

42. SIGNATURE OF DECEASED'S NEAREST RELATIVE

43. SIGNATURE OF DECEASED'S NEAREST RELATIVE

BUREAU V. 1

1955

RECEIVED

DEPT. HEALTH

6191 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH COUNTY <i>An. Anundell</i> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i> OR TOWN <i>N.Y.</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md</i> COUNTY <i>A. A</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Galeville</i> OR TOWN <i>Galeville</i> STREET ADDRESS (If rural give location) <i>Galeville</i>	
3. NAME OF DECEASED (Type or Print) <i>Harry</i> (First) <i>E.</i> (Middle) <i>Foot</i> (Last)		4. DATE OF DEATH (Month) <i>7</i> (Day) <i>2</i> (Year) <i>1955</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>NOV. 9 1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>OYSTER SHUCKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	9. AGE last birthday <i>61</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>GEORGE CLARKSON</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213 05 0091</i>	
17. INFORMANT & ADDRESS <i>Crownville H. Hosp.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 002X IMMEDIATE CAUSE (A) <i>The of lungs</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST, (C)			INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Generalized arteriosclerosis</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <i>July 2, 1955</i>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 2, 1955</i> to <i>July 2, 1955</i> , that I last saw the deceased alive on <i>July 2, 1955</i> , and that death occurred at <i>7:30</i> M. from the causes and on the date stated above.			
SIGNATURE <i>Harry Foot</i>		DATE SIGNED <i>July 2, 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		24. REC'D BY REGISTRAR <i>1/1</i>	
DATE <i>7-12-55</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Harold J. Funerals</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

CERTIFICATE OF DEATH

Reg. Form No. 1

1. NAME OF DECEASED (Print or Write)

DATE OF DEATH

PLACE OF DEATH

BUREAU V. 3

JUL 18 1955

RECEIVED

INSTRUCTIONS

1. This form is to be filled out by the physician or other person who has attended the deceased or who has been in attendance at the death. It should be filled out as soon as possible after death and should be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within 10 days of the date of death. It is the duty of the physician or other person who has attended the deceased to sign this certificate and to file it in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within 10 days of the date of death. It is the duty of the Registrar of the State Department of Health to file this certificate in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within 10 days of the date of death. It is the duty of the Registrar of the State Department of Health to file this certificate in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within 10 days of the date of death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 115C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6192

CERTIFICATE OF DEATH

06187

Reg. Dist. No. 24

Item 9, File 184 8-1-55 et

1. PLACE OF DEATH CITY <u>ARUNDEL</u> COUNTY <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>GLEN BURNIE</u> LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONVALESCENT HOME Route 2 Box 376 A</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> STREET ADDRESS (If rural give location) <u>904 BREVARD ST</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY</u> <u>GAINES</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July</u> <u>21</u> <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>MARCH 19, 1984</u>	9. AGE last birthday <u>71</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MOSES J. GAINES JR.</u>				14. MOTHER'S MAIDEN NAME <u>MARY A. MURPHY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>LEO GAINES</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 491X IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) _____ STATING UNDERLYING CAUSE LAST. DUE TO (C) _____						INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic heart disease. Hemiplegia, left</u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/2</u> , 19 <u>55</u> , to <u>7/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 19</u> , 19 <u>55</u> , and that death occurred at <u>1245 P</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>Joseph A. [Signature]</u>		M.D. <u>102 Balto. Annap. Blvd. Md. [Signature]</u>		DATE SIGNED <u>7/21/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>7/25/55</u>	NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>			
24. REC'D BY REGISTRAR <u>July 26, 1955</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES F. EVANS & SON</u>		ADDRESS <u>118 W. Mt. Royal Ave</u>			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6193

06188

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Edgewater</u>		LENGTH OF STAY (in this place)		OR TOWN <u>EDGEWATER</u>		OR TOWN <u>EDGEWATER</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Georgie</u> (Middle) <u>Frances</u> (Last) <u>GARTON</u>				Month <u>7</u> Day <u>3</u> Year <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAR 25 1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WILLIAM SHIPP</u>				14. MOTHER'S MAIDEN NAME <u>SALLY RAYNOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>ERNIE LEE GARTON (2)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260X IMMEDIATE CAUSE (A) <u>Gastrointestinal hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Gastric ulcer</u>				<u>15 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes mellitus</u>				<u>5 years??</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>1. Atherosclerosis</u>			
				<u>2. Old cerebrovascular accident</u>			
				<u>3. Congestive cardiac failure chronic</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY		20. AUTOPSY	
				Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>December 19, 54</u> , to <u>2 July, 1955</u> , that I last saw the deceased alive on <u>2 July, 1955</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Franklin D. Hendrick</u>				ADDRESS (Street, city, town, state) <u>Shady Side, Maryland</u>			
DATE SIGNED <u>4 July 55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>7-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>Church Cem.</u>		LOCATION (City, town, or county) (State) <u>Madison Co. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edward Collins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>FREDDY FUNERAL HOME</u>		ADDRESS <u>ORANGE Va.</u>	
DATE <u>7/9/55</u>							

CERTIFICATE OF DEATH

Form 10-55

INVESTIGATION OF DEATH

DATE OF DEATH

August 1, 1955
Baltimore

Age 72
Sex F
Race W
Married

Place of Birth
Date of Birth

Occupation
Cause of Death
Manner of Death

Signature of Physician
Signature of Registrar

DATE OF DEATH
TIME OF DEATH

RECEIVED
JUL 11 1955

INSTRUCTIONS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

 20&21
 Items 18, Film G185 8-12-55 ams

6194

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

06189

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town) Crownsville		LENGTH OF STAY (in this place) 15 yrs, 9 mos.		CITY (If outside corporate limits, write RURAL and give nearest town) Bel Air		12-32-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) None listed			
3. NAME OF DECEASED (Type or Print) Clark Green, Jr.				4. DATE OF DEATH (Month) (Day) (Year) 7 16 19 55			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH November, 1933	9. AGE last birthday 21 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Bertha Green				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Hospital Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						5/1/55	
351X IMMEDIATE CAUSE (A) Exhaustion due to extensive burns (3rd degree)							
ANTECEDENT CAUSE(S) DUE TO (B) Idiocy with spastic tetraplegia						Congenital	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) 9/17/7							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Exhaustion due to extensive burns (3rd degree)						5/1/55	
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Shower Room		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) Baltimore for mentally Deficient			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 5/1/55		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Scalded in Shower			
22. I hereby certify that I attended the deceased from 1/5 , 19 55 , to 7/16/55 , 19 55 , that I last saw the deceased alive on 7/16 , 19 55 , and that death occurred at 2:30 PM , from the causes and on the date stated above.							
SIGNATURE Hildreath Heard Reidman				ADDRESS (Street, city, town, state) Crownsville, Md.			
DATE SIGNED 7/17/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 7/20/55		NAME OF CEMETERY OR CREMATORY University Medical School		LOCATION (City, town, or county) (State) Baltimore Md.	
24. REC'D BY REGISTRAR 7-20-55		REGISTRAR'S SIGNATURE K.M. Joyce		25. FUNERAL DIRECTOR'S SIGNATURE Frances A. Klemm		ADDRESS 578 W. Biddle St.	

CERTIFICATE OF DEATH

Reg. Dist. No. 22

LOCAL HEALTH OFFICER'S SIGNATURE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

LOCAL HEALTH OFFICER'S SIGNATURE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. S.

APR 22 1911

RECEIVED

APR 22 1911

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6165

CERTIFICATE OF DEATH

06190

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>129 Spa View Ave</u>				STREET ADDRESS (If rural give location) <u>129 Spa View Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>CHARLOTTE</u> (Middle) <u>R.</u> (Last) <u>HARBOLD</u>				July 6, 1955 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>May 19, 1911</u>	<u>44</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>School teacher</u>		<u>Jr. High</u>		<u>Annapolis, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Roscoe C. Rowe</u>				<u>Regina C. Dammeyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>Mr. Robert P. Harbold Jr.-Husband as #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
170X IMMEDIATE CAUSE (A) <u>METASTATIC CARCINOMA TO BRAIN</u>						<u>6-7 WKS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA OF BREAST</u>						<u>5 YRS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/5</u> , 19 <u>55</u> , to <u>7/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/6</u> , 19 <u>55</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward J. Beck</u>				ADDRESS (Street, city, town, state) <u>4 Southgate Ave Annapolis</u> DATE SIGNED <u>7/6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 8, 1955</u>		<u>Cedar Bluff Cemetery</u>		<u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>July 7, 1955</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>HOPPING FUNERAL HOME ANNAPOIS, MD.</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

JUL 8 1955

RECEIVED

NOTICE

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS LOANED TO YOU FOR YOUR INFORMATION. IT IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM. ANY VIOLATION OF THIS NOTICE IS A VIOLATION OF THE FEDERAL COPYRIGHT ACT OF 1909 AND MAY BE SUBJECT TO CIVIL AND CRIMINAL PENALTIES. THE STATE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR ANY ERRORS OR OMISSIONS IN THIS CERTIFICATE. THE SIGNATURE OF THE REGISTRAR IS REQUIRED FOR THIS CERTIFICATE TO BE VALID. THE SIGNATURE OF THE REGISTRAR IS REQUIRED FOR THIS CERTIFICATE TO BE VALID.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6195

CERTIFICATE OF DEATH

06191

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>aa</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>aa</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Sudley</u>		LENGTH OF STAY (in this place) <u>20 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sudley</u>		TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Paul Oliver Hardisty</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 18 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 22 1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		11. BIRTHPLACE (State or foreign country) <u>Sudley Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Oliver Hardisty</u>				14. MOTHER'S MAIDEN NAME <u>Martha B. Crandall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes WWI</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Isionette Hardisty West River P.O. MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
157X IMMEDIATE CAUSE (A) <u>Carcinoma head & pancreas</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>6/10/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>metastatic Carcinoma pancreas</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/12</u> to <u>July 15</u> 19 <u>55</u> that I last saw the deceased alive on <u>July 15</u> 19 <u>55</u> and that death occurred at <u>9:30 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Emily H. Wilem</u>				DATE SIGNED <u>7/20/55</u>			
ADDRESS (Street, city, town, state) <u>Lothian, md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Zion</u>		LOCATION (City, town, or county) <u>Galesville Md</u>	
24. REC'D BY REGISTRAR <u>7-25-55</u>		REGISTRAR'S SIGNATURE <u>J. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Galesville Md</u>	

CERTIFICATE OF DEATH

Form No. 100-104

1. PLACE OF BIRTH

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JUDGE

14. SIGNATURE OF SHERIFF

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF COURT

18. SIGNATURE OF STATE

19. SIGNATURE OF COUNTY

20. SIGNATURE OF CITY

21. SIGNATURE OF TOWN

22. SIGNATURE OF VILLAGE

23. SIGNATURE OF POST OFFICE

24. SIGNATURE OF SCHOOL

25. SIGNATURE OF CHURCH

26. SIGNATURE OF SYNAGOGUE

27. SIGNATURE OF MOSQUE

28. SIGNATURE OF TEMPLE

29. SIGNATURE OF MONASTERY

30. SIGNATURE OF CONVENT

31. SIGNATURE OF NUNNERY

32. SIGNATURE OF HERMITAGE

33. SIGNATURE OF RETIREMENT HOME

34. SIGNATURE OF NURSING HOME

35. SIGNATURE OF HOSPITAL

36. SIGNATURE OF CLINIC

37. SIGNATURE OF DISPENSARY

38. SIGNATURE OF PHARMACY

39. SIGNATURE OF LABORATORY

40. SIGNATURE OF OFFICE

41. SIGNATURE OF STORE

42. SIGNATURE OF RESTAURANT

43. SIGNATURE OF BAR

44. SIGNATURE OF CAFE

45. SIGNATURE OF DINING ROOM

46. SIGNATURE OF KITCHEN

47. SIGNATURE OF PANTRY

48. SIGNATURE OF BUTLER

49. SIGNATURE OF COOK

50. SIGNATURE OF WAITER

51. SIGNATURE OF BARBER

52. SIGNATURE OF BEAUTICIAN

53. SIGNATURE OF HAIR DRESSER

54. SIGNATURE OF NAIL TECHNICIAN

55. SIGNATURE OF COSMETOLOGIST

56. SIGNATURE OF MASSAGE THERAPIST

57. SIGNATURE OF CHIROPRACTOR

58. SIGNATURE OF YOGI

59. SIGNATURE OF MEDITATION INSTRUCTOR

60. SIGNATURE OF OTHER

BUREAU V. 8

JUL 26 1955

RECEIVED

2007/07/26

1

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6196

CERTIFICATE OF DEATH

06192

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
TOWN <u>Glen Burnie</u>		LENGTH OF STAY (in this place)		TOWN <u>Glen Burnie</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 PLAZA MANOR CONDOMINIUM HOME Route 2 Box 376A</u>				STREET ADDRESS <u>2815 Presstman Street</u>			
3. NAME OF DECEASED (First) <u>CLARA</u> (Middle) <u>HARDY</u> (Last)				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb-14th.-1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Solman Travers</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wheller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Roland Hardy 531 W. Hoffman St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Hypertensive cardiovascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis, General</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1955</u> , to <u>1955</u> , that I last saw the deceased <u>alive on</u> <u>9/15</u> , and that death occurred at <u>9:15</u> M. from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> M.D. <u>N.E. GLEN BURNIE, Md.</u> DATE SIGNED <u>7/26/55</u> ADDRESS (Street, city, town, state) <u>1025 ALTIMORE ANNAPOLIS, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Arburn Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>July 26, 1955</u>		REGISTRAR'S SIGNATURE <u>Louis J. DeAlto</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u> ADDRESS <u>1000 Brantley Ave.</u>			

CERTIFICATE OF DEATH

How Completed

1. Name of deceased (Print or write in full)

MARYLAND
COUNTY OF

CITY OF

2. Date of death (Month, day, year)

3. Time of death (Hour, minute)

4. Place of death (Street, city, state)

5. Cause of death (Immediate cause)

6. Cause of death (Underlying cause)

7. Cause of death (Contributing cause)

8. Name of physician (Print or write in full)

9. Name of medical examiner (Print or write in full)

10. Name of coroner (Print or write in full)

11. Name of funeral home (Print or write in full)

12. Name of cemetery (Print or write in full)

13. Name of burial place (Print or write in full)

14. Name of informant (Print or write in full)

15. Name of registrar (Print or write in full)

16. Name of clerk (Print or write in full)

17. Name of witness (Print or write in full)

18. Name of witness (Print or write in full)

19. Name of witness (Print or write in full)

20. Name of witness (Print or write in full)

21. Name of witness (Print or write in full)

22. Name of witness (Print or write in full)

23. Name of witness (Print or write in full)

24. Name of witness (Print or write in full)

25. Name of witness (Print or write in full)

26. Name of witness (Print or write in full)

27. Name of witness (Print or write in full)

28. Name of witness (Print or write in full)

29. Name of witness (Print or write in full)

30. Name of witness (Print or write in full)

31. Name of witness (Print or write in full)

32. Name of witness (Print or write in full)

33. Name of witness (Print or write in full)

34. Name of witness (Print or write in full)

35. Name of witness (Print or write in full)

36. Name of witness (Print or write in full)

37. Name of witness (Print or write in full)

38. Name of witness (Print or write in full)

39. Name of witness (Print or write in full)

40. Name of witness (Print or write in full)

39. Name of witness (Print or write in full)

40. Name of witness (Print or write in full)

41. Name of witness (Print or write in full)

40. Name of witness (Print or write in full)

41. Name of witness (Print or write in full)

42. Name of witness (Print or write in full)

41. Name of witness (Print or write in full)

42. Name of witness (Print or write in full)

43. Name of witness (Print or write in full)

42. Name of witness (Print or write in full)

43. Name of witness (Print or write in full)

44. Name of witness (Print or write in full)

43. Name of witness (Print or write in full)

44. Name of witness (Print or write in full)

45. Name of witness (Print or write in full)

44. Name of witness (Print or write in full)

45. Name of witness (Print or write in full)

46. Name of witness (Print or write in full)

45. Name of witness (Print or write in full)

46. Name of witness (Print or write in full)

47. Name of witness (Print or write in full)

BUREAU Y. 2

JUL 29 1955

RECEIVED

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6197

CERTIFICATE OF DEATH

06193

Reg. Dist. No. 28

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>AA</u>	MARYLAND	STATE <u>Md</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	<u>3V01-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville Md</u>		STREET ADDRESS (If not give location) <u>1316 W. Mather Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Carrie Haskins</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7 15 55</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>5-1-93</u>
9. AGE last birthday <u>62</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homework</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS <u>1316 W. Mather St Baltimore</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>782.4 IMMEDIATE CAUSE (A) <u>Heart failure</u></u>			<u>2 weeks</u>
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-14</u> 19 <u>55</u> , to <u>7-15-55</u> , that I last saw the deceased alive on <u>7-11</u> 19 <u>55</u> , and that death occurred at <u>1:35 PM</u> M, from the causes and on the date stated above.			
SIGNATURE <u>NBP Kim</u>		ADDRESS (Street, city, town, state) DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-19-55</u>	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORY <u>mont auburn</u>	
REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>		LOCATION (City, town, or county) (State) <u>md</u>	
DATE <u>7/18/55</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George S. Nelson</u> ADDRESS <u>1348 n. calhoun st</u>	

CERTIFICATE OF DEATH

Form 100-10-1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF JAILER

20. SIGNATURE OF PRISONER

21. SIGNATURE OF WARDEN

22. SIGNATURE OF CHIEF CLERK

23. SIGNATURE OF DEPUTY CHIEF CLERK

24. SIGNATURE OF RECORDS CLERK

25. SIGNATURE OF FILE CLERK

26. SIGNATURE OF INDEX CLERK

27. SIGNATURE OF SEARCH CLERK

28. SIGNATURE OF ASSISTANT CLERK

29. SIGNATURE OF CLERICAL ASSISTANT

30. SIGNATURE OF CLERICAL ASSISTANT

31. SIGNATURE OF CLERICAL ASSISTANT

32. SIGNATURE OF CLERICAL ASSISTANT

33. SIGNATURE OF CLERICAL ASSISTANT

34. SIGNATURE OF CLERICAL ASSISTANT

BUREAU V. 2

MAR 18 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6193

CERTIFICATE OF DEATH

06194

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		<u>1yr. 8mos. 11 days</u>		TOWN <u>Baltimore City</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>3316 Hawkins Point Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Annabelle</u> (Middle) <u>Hearn</u> (Last)				(Month) <u>7</u> (Day) <u>7</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Negro</u>	<u>Widowed</u>	<u>Unknown</u>	<u>72?</u> yrs.	Months <u>-</u> Days <u>-</u>	Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unknown</u>		<u>Unk.</u>		<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME <u>John Parker</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Hypertensive Cardiovascular Disease</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
1025X STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CNS Syphilis - Psychosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>7</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/5</u> , 19 <u>55</u> , to <u>7/7</u> , 19 <u>55</u> , that I last saw the deceased live on <u>7/7</u> , 19 <u>55</u> , and that death occurred at <u>4:30p.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Harold Heard Reiss</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>7/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 11-1955</u>		<u>Int Calvary Cemetery A. A. B. Md</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>7-11-55</u>		<u>Pratherme Joyce</u>		<u>Robert Williams</u>		<u>1701 N Bond St</u>	

INSTRUCTIONS

1. This form is to be filled out by the attending physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and should be submitted to the local health department or the coroner's office. It is not to be filled out for a person who has died of a natural cause, such as old age, heart disease, or cancer, unless there is some reason to doubt the cause of death. It is to be filled out for a person who has died of an accident, suicide, or homicide, or for a person who has died of a disease of unknown cause. It is to be filled out for a person who has died of a disease of known cause, such as pneumonia, tuberculosis, or diabetes, unless the cause of death is obvious to the attending physician. It is to be filled out for a person who has died of a disease of known cause, such as pneumonia, tuberculosis, or diabetes, unless the cause of death is obvious to the attending physician. It is to be filled out for a person who has died of a disease of known cause, such as pneumonia, tuberculosis, or diabetes, unless the cause of death is obvious to the attending physician.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of attending physician	
10. Signature of registrar		11. Date of registration		12. Place of registration	

BUREAU V. S.

JUL 12 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

06195

6199

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

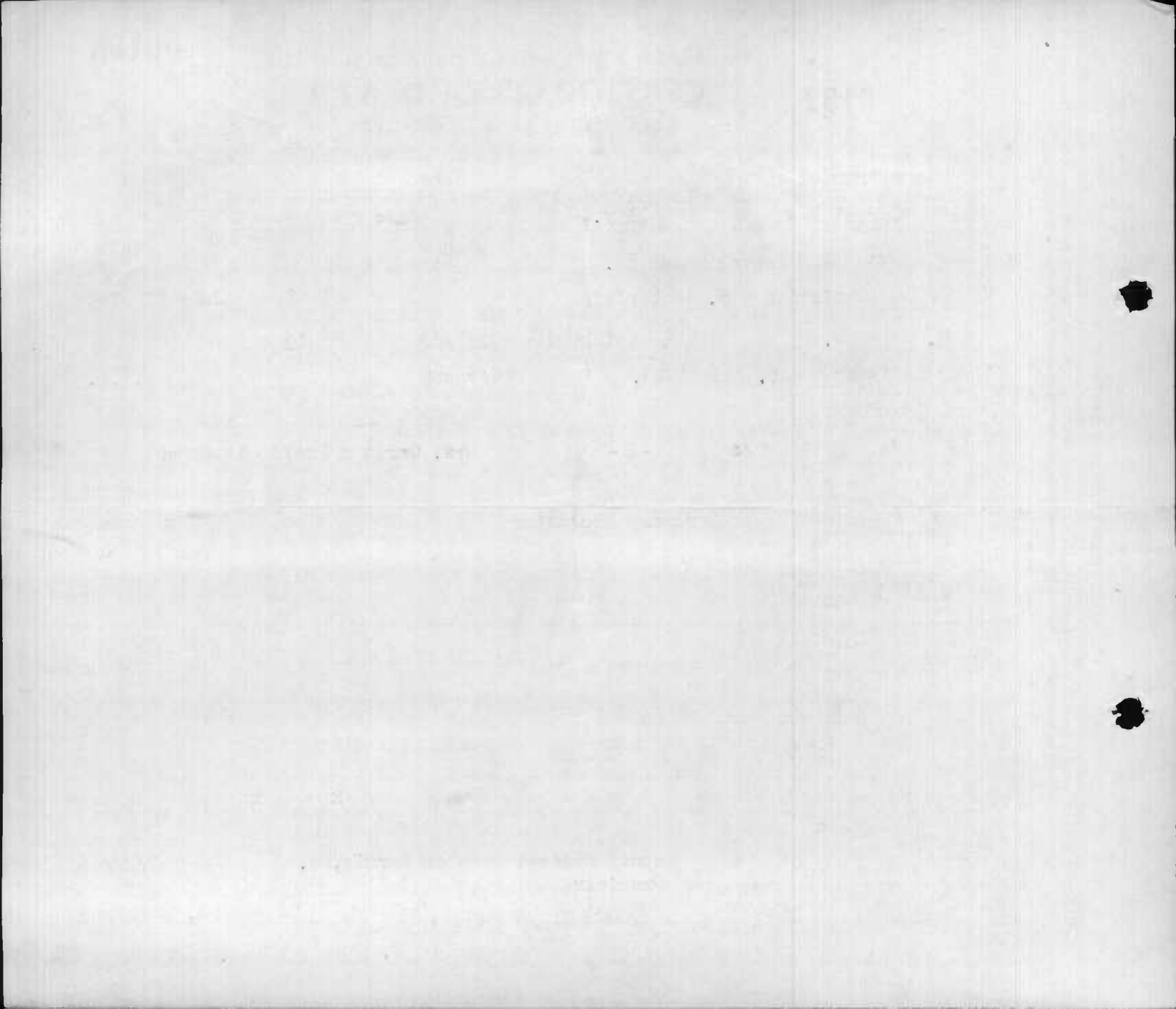
1. PLACE OF DEATH- COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL and give nearest town) Carvel Beach TOWN Carvel Beach HOSPITAL OR INSTITUTION OR STREET ADDRESS 422 Carvel Beach Rd.		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Same COUNTY Same CITY (If outside corporate limits, write RURAL and give nearest town) Same TOWN Same STREET ADDRESS (If rural, give location) Same	
3. NAME OF DECEASED (Type or Print) Christian F. Heberlein (First) (Middle) (Last)		4. DATE OF DEATH July 22 1955 (Month) (Day) (Year)	
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 1/1/82 9. AGE last birthday 73 yrs. If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work or during most of working life, even if retired) Silver Polisher Ret. Stieff Co.		10b. KIND OF BUSINESS OR INDUSTRY Ret. Stieff Co.	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Karl Heberlein		14. MOTHER'S MAIDEN NAME Gertrude	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or service)		16. SOCIAL SECURITY No. 215-01-7075	
17. INFORMANT Mrs. Carlton Treff (daughter)			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Coronary Occlusion Immediate cause (a) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION 0	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE Glen Burnie, Md. Deputy Medical Examiner		DATE SIGNED 7/22/55
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 7/26/55	NAME OF CEMETERY OR CREMATORY Parkwood Cemetery
DATE REC'D BY LOCAL REG. 7-25-55	REGISTRAR'S SIGNATURE Leonard J. Ruck	LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Leonard J. Ruck		ADDRESS 5305 Harford Road #14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

06196

6300

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL and give nearest town) Severn TOWN Severn HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Ave.		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Same COUNTY Same CITY (If outside corporate limits, write RURAL and give nearest town) Same TOWN Same STREET ADDRESS (If rural, give location) Same	
3. NAME OF DECEASED (Type or Print) Charles Edwin Hickerson (First) (Middle) (Last)		4. DATE OF DEATH July 21st. 1955 (Month) (Day) (Year)	
5. SEX M.	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 10/11/85 9. AGE last birthday 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired PBX operator at the District Training School.		11. BIRTHPLACE (State or foreign country) Brooklyn, N.Y.	
13. FATHER'S NAME William H. Hickerson		14. MOTHER'S MAIDEN NAME ? UNKNOWN-	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		17. INFORMANT Mrs. Anna H. Hickerson, (Wife)	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Coronary Occlusion Immediate cause (a) Sudden. Antecedent cause(s) (b) Immediate cause Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 09	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE Gordon H. Paulsen (Degree or title) Deputy Medical Examiner.		DATE SIGNED 7/22/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF July 23, 1955	NAME OF CEMETERY OR CREMATORY White Marsh Ck. Cemetery	LOCATION (City, town, or county) (State) Lancaster County Va
DATE REC'D BY LOCAL REG. July 23, 1955	REGISTRAR'S SIGNATURE F. J. De Alba	24. FUNERAL DIRECTOR W. Doughton	ADDRESS Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 25 1955

RECEIVED

6201

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND				STATE <u>GLEW BURNIE</u> COUNTY <u>AA</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riva</u> LENGTH OF STAY (In this place) <u>17 mos</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Brecken Nursing Home</u>				STREET ADDRESS (If rural give location) <u>104 A St. S.W.</u>			
3. NAME OF DECEASED: (First) <u>CHARLES</u> (Middle) <u>G</u> (Last) <u>HILL</u>				4. DATE OF DEATH: (Month) <u>JULY</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>		8. DATE OF BIRTH: <u>AUG 14 1876</u> 78 yrs.	
9. AGE last birthday: <u>78</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>JUDGE</u>		11. BIRTHPLACE (State or foreign country): <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Joseph Alonzo Hill</u>				14. MOTHER'S MAIDEN NAME: <u>Helena Green</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Dr Chas Hill, Glen Burnie</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Heart Failure</u>		<u>10 yrs</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>arteriosclerotic Heart Disease</u>		
(c) <u>Cerebral vascular accident</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION: <u>None</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		PLACE (Home, farm, factory, street, or office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 19 54 to late 1954, that I last saw the deceased alive on July 2, 19 55 and that death occurred at Riva 7/4/55 6am from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>July 6-1955</u>	NAME OF CEMETERY OR CREMATORY <u>St. Paul's Episcopal Church</u>	LOCATION (City, town, or county) (State) <u>Crownsville, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>July 3, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. French</u>		24. FUNERAL DIRECTOR ADDRESS <u>51 Southgate Dr. R. V. Singleton - Glen Burnie, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1955

BUREAU V. S.

6166

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Q. Q.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Q. Q.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
63 <u>A. C. General</u>				147 <u>King George</u>		1	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles D.</u> (Middle) <u>Hyde</u> (Last)				DATE OF DEATH <u>7</u> (Month) <u>5</u> (Day) 19 <u>55</u> (Year)			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>W</u>	<u>Married</u>	<u>12-24-1889</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Plumber</u>		<u>Plumber</u>		<u>Baltimore Md.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles D. Hyde</u>				<u>Ida Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		(2)	
<u>yes World War I</u>		<u>—</u>		<u>Bertha V. Hyde</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
196X IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-24</u> , 19 <u>65</u> , to <u>7-5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7-5</u> , 19 <u>55</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>Handwritten Signature</u> M. D.				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7/7/55</u>		<u>Arlington</u>		<u>VA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>July 7, 1955</u>		<u>John M. Taylor</u>		<u>John M. Taylor</u>		<u>Annapolis Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John T. Smith</i>		2. PLACE OF DEATH <i>Home</i>	
3. DATE OF DEATH <i>July 8, 1955</i>		4. TIME OF DEATH <i>10:30 AM</i>	
5. SEX <i>Male</i>		6. AGE <i>65</i>	
7. OCCUPATION <i>Teacher</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. PLACE OF BIRTH <i>Baltimore, Md.</i>		10. DATE OF BIRTH <i>July 15, 1890</i>	
11. MARITAL STATUS <i>Married</i>		12. NAME OF SPOUSE <i>John T. Smith</i>	
13. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. NAME OF HOSPITAL <i>None</i>	
15. NAME OF FUNERAL HOME <i>John T. Smith</i>		16. NAME OF MINISTER <i>Rev. J. H. Smith</i>	
17. NAME OF BURIAL PLACE <i>St. John's Church</i>		18. NAME OF CEMETERY <i>St. John's Cemetery</i>	
19. NAME OF INTERVIEWER <i>John T. Smith</i>		20. NAME OF WITNESS <i>John T. Smith</i>	

John T. Smith
Teacher
St. John's Church

BUREAU V. S.

JUL 8 1955

RECEIVED

100-1012241

06199

MARYLAND STATE DEPARTMENT OF HEALTH

6202

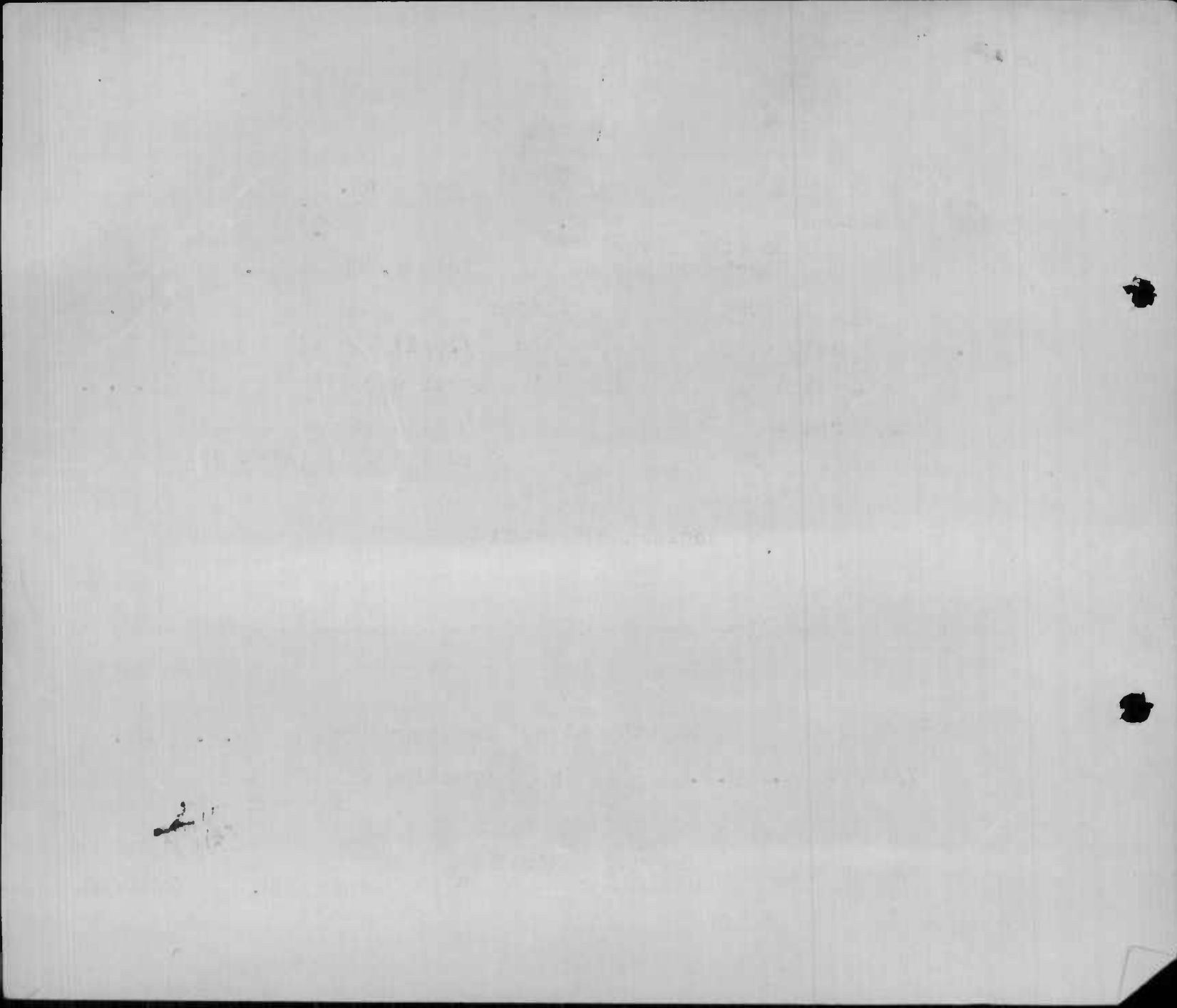
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH - COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Pasadena		LENGTH OF STAY (In this place) 1 hr.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Magothy River off Beechwood Beach				STREET ADDRESS (If rural, give location) 1310 E. Chase St.			
3. NAME OF DECEASED (First) (Middle) (Last) Frances Jacobs		4. DATE OF DEATH (Month) (Day) (Year) July 15th, 1955		5. SEX F.		6. COLOR OR RACE Colored	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated		8. DATE OF BIRTH 2/15/11		9. AGE last birthday 44 yrs.		10. If under 1 year (Months) (Days) (Hours) (Mins.)	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Troddon		14. MOTHER'S MAIDEN NAME Ella Woods		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Cordelia Tull (sister)		18. MEDICAL CERTIFICATION		1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 9298 Immediate cause (a) Accidental Drowning Sudden Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 7/15/55		19b. MAJOR FINDINGS OF OPERATION Drowning		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH TIME (Month) (Day) (Year) (Hour) OF INJURY 7/15/55 10.30p.m.		PLACE (Home, farm, factory, street, OF INJURY) Magothy River		(CITY OR TOWN) Beechwood Beach		(COUNTY) (STATE) A.A. Md.	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE Deputy Medical Examiner		DATE THEREOF 7-19-55		NAME OF CEMETERY OR CREMATORY My Calvary Cem		LOCATION (City, town, or county) (State) A.A. Co Md	
DATE REC'D BY LOCAL REG. 7/18/55		REGISTRAR'S SIGNATURE W. Hedrich		24. FUNERAL DIRECTOR Rayner Sanders		ADDRESS 217 E. Preston St	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6203

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06200

Reg. Dist.

No. 21

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u> MARYLAND	CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural Annapolis</u>	STATE <u>D. C.</u> COUNTY	CITY (If outside corporate limits write RURAL and give nearest town) <u>Washington</u> 47X-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sparrows Beach</u>	LENGTH OF STAY (in this place)	STREET ADDRESS (If rural, give location)	<u>1610 Calcaran St.</u>
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Carl</u>	(Middle) <u>Thompson</u>	(Last) <u>Jennings</u>	(Month) <u>July</u> (Day) <u>31</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S.</u>	8. DATE OF BIRTH: <u>2-23-1934</u>
9. AGE last birthday: <u>21</u> yrs.		10. AGE last birthday: <u>21</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, or if retired): <u>Freight Operator Animal Research</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Shelby, D.C.</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Everett Jennings</u>		14. MOTHER'S MAIDEN NAME: <u>Cadietha Cornuthers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>770</u>	
17. INFORMANT & ADDRESS: <u>Everett Jennings - 65 Randolph Pl. N.W. Wash. D.C.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
929.8 Immediate cause (a) <u>Drowning</u> DUE TO		<u>Sudden</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) DUE TO		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>8-5-55</u>		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Beach</u>)	21c. (City or town) <u>H.A. Co.</u> (County) <u>MD</u> (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7 31 55</u> <u>A</u> M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>While at Sparrows Beach</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Edmund Hall</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/31/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>8-5-55</u>	NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>
DATE REC'D BY LOCAL REG. <u>Aug. 1, 1955</u>	REGISTERING SIGNATURE <u>J. J. Smith</u>	LOCATION (City, town, or county) <u>Prin. Geo. Co.</u> (State) <u>Maryland</u>
24. FUNERAL DIRECTOR <u>Fraser Funeral Home</u>		ADDRESS <u>Washington, D.C.</u> <u>389 R. I. Ave. N.W.</u>

Gold Thompson Jennings

BUREAU V. 2

AUG 3 1955

RECEIVED

6204

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
 TOWN Glen Burnie
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Playa Maria Nursing Home
Box 376-A, Rt 2, Glen Burnie

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Balto. Co.
 CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore
 TOWN Baltimore
 STREET ADDRESS (If rural give location) 1371 N. Stricker

3. NAME OF DECEASED:

(First) MARY (Middle) (n) (Last) JOHNSON
 (Type or Print)

4. DATE OF DEATH: (Month) JULY (Day) 5 (Year) 1955

5. SEX:

F

6. COLOR OR RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Wid.

8. DATE OF BIRTH: 4 July 1882

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): St. Mary's County, Md.

12. CITIZEN OF WHAT COUNTRY? Yes - USA

13. FATHER'S NAME:

not known

14. MOTHER'S MAIDEN NAME:

Liza Hill

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS:

808 W. Lenoir St. Balto.
Mrs. Jennie Hawkins (granddaughter)

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
 Immediate cause

(a)

Cerebral Vascular Accident

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

Hypertension

DUE TO

(c)

Interval Between Onset And Death

1 day

10 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

General Arteriosclerosis

10 yrs

19a. DATE OF OPERATION:

none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased

alive on _____, 19_____, and that death occurred at _____, from the causes and on the date stated above.

(Degree or title)

ADDRESS

DATE SIGNED

H. F. Manuyak M.D. 901 Edgerly Rd. Glen Burnie, Md. 5 July 1955

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

7-8-55

NAME OF CEMETERY OR CREMATORY

St. Mary's

LOCATION (City, town, or county) (State)

Baltimore Maryland

DATE REC'D BY LOCAL REGISTRAR

55

REGISTRAR'S SIGNATURE

[Signature]

24. FUNERAL DIRECTOR

Thomas C. Delaney

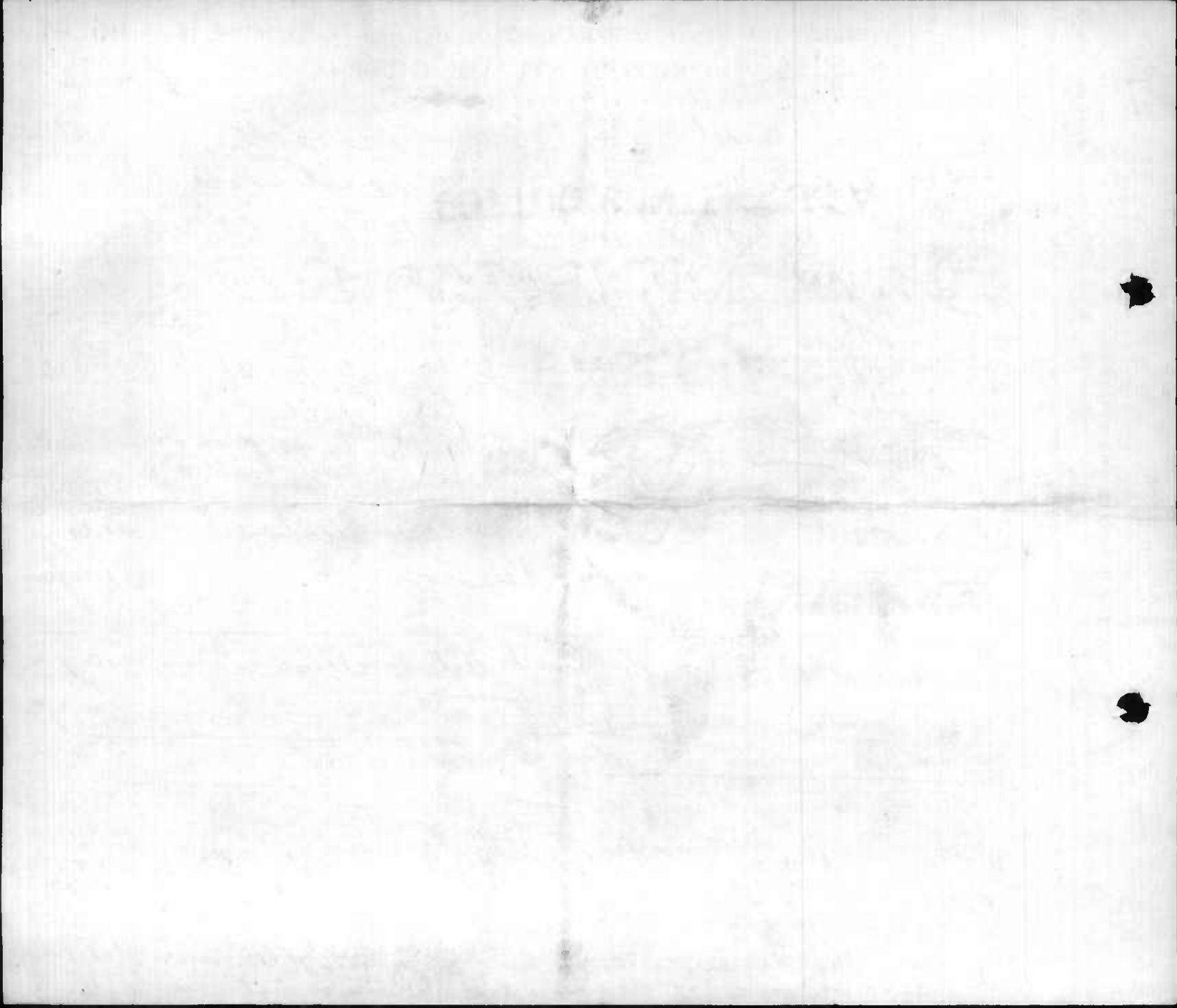
ADDRESS

1303 Chestnut St.

NOTE: This patient has been under the care of Dr. J. J. Baker of Glen Burnie at this nursing home & was called to pronounce her dead when he was not available.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06202

6205

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Crownsville</u>		<u>2 yrs. 2 mos. 23 days</u>		TOWN <u>Baltimore City</u>		<u>3 Vol 1-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1051 Argyle Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Bell</u> (Last) <u>Johnson</u>				(Month) <u>7</u> (Day) <u>16</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FE MALE</u>	<u>Negro</u>	<u>Widow</u>	<u>Unknown</u>	<u>78?</u> yrs.	Months <u>-</u> Days <u>-</u>	Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>George Yeager</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service) <u>Unk.</u>			16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Senile Atrophy of the brain</u>						Known to us since <u>4/23/52</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Purulent Cholecystitis</u>						Unknown	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>2</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>1/5</u> , 19 <u>55</u> , to <u>7/16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/16</u> , 19 <u>55</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Hildyard Heard Reisman</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>			
DATE SIGNED <u>7/17/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN</u>		LOCATION (City, town, or county) <u>BALTO; Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>July 20, 1955</u>		<u>Platterman M. Joyce</u>		<u>Joseph S. Locks</u>		<u>1304 N. Central</u>	

NOTIFICATION

THIS IS TO CERTIFY THAT THE FOLLOWING PERSON HAS BEEN DECEASED AND THAT THE DEATH HAS BEEN REPORTED TO THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. NAME OF DECEASED		2. SEX		3. AGE	
John Doe		Male		45	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
Baltimore, Maryland		January 1, 1910		January 1, 1955	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
Baltimore, Maryland		Heart Disease		Natural	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF WITNESSES		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESSES		27. SIGNATURE OF DECEASED	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF WITNESSES		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESSES		33. SIGNATURE OF DECEASED	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF WITNESSES		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF WITNESSES		39. SIGNATURE OF DECEASED	
40. SIGNATURE OF DECEASED		41. SIGNATURE OF WITNESSES		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF WITNESSES		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESSES		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF WITNESSES		51. SIGNATURE OF DECEASED	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF WITNESSES		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF WITNESSES		57. SIGNATURE OF DECEASED	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF WITNESSES		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESSES		63. SIGNATURE OF DECEASED	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF WITNESSES		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF WITNESSES		69. SIGNATURE OF DECEASED	
70. SIGNATURE OF DECEASED		71. SIGNATURE OF WITNESSES		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF WITNESSES		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF WITNESSES		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF WITNESSES		81. SIGNATURE OF DECEASED	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF WITNESSES		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF WITNESSES		87. SIGNATURE OF DECEASED	
88. SIGNATURE OF DECEASED		89. SIGNATURE OF WITNESSES		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESSES		93. SIGNATURE OF DECEASED	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF WITNESSES		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF WITNESSES		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF WITNESSES		102. SIGNATURE OF DECEASED	

Corporal V. J. Doe

Corporal V. J. Doe

BUREAU A. 3

JUL 20 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06203

6203

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		<u>1 mo. 23 days</u>		TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>10 Crownsville State Hospital</u>				<u>1638 Miller Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Mary Wyatt Jones</u>				<u>7 9 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Negro</u>	<u>Married</u>	<u>7 4 88</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unknown</u>		<u>Unknown</u>		<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>David Wyatt</u>				<u>Rebecca Wyatt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>Unknown</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Hypostatic Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive and Arteriosclerotic Heart Disease</u>						<u>48 hrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/18</u> , 19 <u>55</u> , to <u>7/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/9</u> , 19 <u>55</u> , and that death occurred at <u>5:15 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>John A. Hamilton</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>7/10/55</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>7/13/55</u>		<u>Arboretum Mon. Pl.</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>7-12-55</u>		<u>A.W. Hedrich</u>		<u>Randolph Collick</u>		<u>1412 E. Preston</u>	

BUREAU V. S.

JUL 13 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
6207 **CERTIFICATE OF DEATH**
FOR MEDICAL EXAMINERS

06204

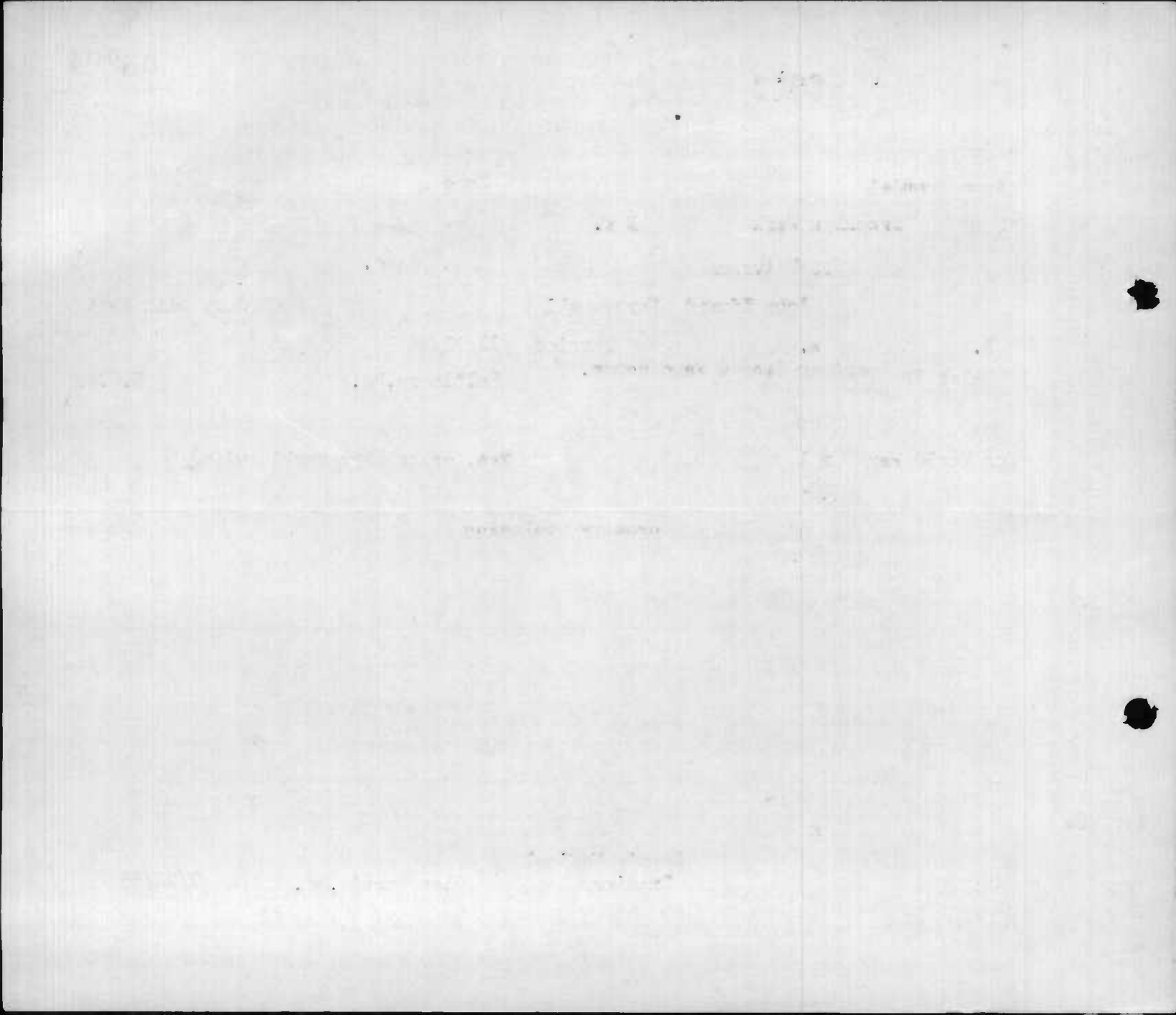
Reg. Dist. No. 25

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Same</u> COUNTY <u>Same</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Brooklyn Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Same</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>422-V-Avenue</u>		STREET ADDRESS (If rural, give location) <u>Same</u>	
3. NAME OF DECEASED (Type or Print) <u>John Edward Karczewski</u>		4. DATE OF DEATH <u>July 24th 1955</u>	
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>11/11/98</u>	
9. AGE last birthday <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of year) <u>Baker in American Stores</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Karczewski</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Mams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War service # 1</u>		16. SOCIAL SECURITY NO. <u>219-03-2361</u>	
17. INFORMANT <u>Mrs. Grace Karczewski (wife)</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u>		<u>Sudden</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Eustace K. Karczewski</u>		DATE SIGNED <u>7/24/55</u>	
Deputy Medical Examiner		Glen Burnie, Md.	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>July 27, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) <u>Balto.</u>	
DATE REC'D BY LOCAL REG. <u>7-26-55</u>		24. FUNERAL DIRECTOR <u>John F. Penfel</u>	
REGISTRAR'S SIGNATURE <u>A. W. Bedard</u>		ADDRESS <u>5311 Edmondson Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6167 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: <u>Annapolis</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>A.A.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>10 Annapolis</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>	<u>10</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Cohen's Nursing Home Annapolis, Md.</u>		STREET ADDRESS (If rural give location) <u>17 Cathedral</u>	<u>1</u>
3. NAME OF DECEASED: (First) <u>Flora</u> (Middle) <u>Monde</u> (Last) <u>Kashner</u>		4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>26</u> (Year) <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>MAY 13, 1890</u>
		9. AGE last birthday: <u>65</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>SALESWOMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>MILLINER</u>	11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME: <u>FERDINAND FEESLER</u>		14. MOTHER'S MAIDEN NAME: <u>MATILDA FEESLER HEISE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>4</u>	
17. INFORMANT & ADDRESS: <u>BUSINESS PARTNER MRS A. GASKIN #2</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset and Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>153X</u> Immediate cause (a) <u>INTESTINAL CARCINOMA</u> DUE TO Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>DUE TO</u> (c)		<u>2 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None.</u>		
19a. DATE OF OPERATION: <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>52</u> , to <u>JULY</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 20</u> , 19 <u>55</u> , and that death occurred at <u>8:07 PM</u> , from the causes and on the date stated above. SIGNATURE <u>John E. Hedeman</u> (Degree or title) <u>M.D.</u> ADDRESS <u>90 Cathedral St.</u> DATE SIGNED <u>7/26/55</u>		
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>burial</u>	<u>7-29-55</u>	<u>St. Anne's</u>
DATE REC'D BY LOCAL REGISTRAR <u>July 28, 1955</u>	REGISTERING PHYSICIAN'S SIGNATURE <u>[Signature]</u>	LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
24. FUNERAL DIRECTOR		ADDRESS
<u>John M. Taylor & Sons</u>		<u>Annapolis, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 29 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6208

CERTIFICATE OF DEATH

06206

27

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Fort George G. Meade</u>		LENGTH OF STAY (in this place) <u>4 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glen Burnie</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 U. S. Army Hospital</u>		STREET ADDRESS <u>1239 Guilford Road</u>		(If rural give location)		<u>/</u>	
3. NAME OF DECEASED (First) <u>ROGER</u> (Middle) <u>JESSEN</u> (Last) <u>KELSO</u>				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>10</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>6 July 1955</u>	9. AGE last birthday yrs. <u>4</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Robert Kelso</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Jessen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Father, 1239 Guilford Road, Glen Burnie, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>763.5 Aspiration pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6 July</u> , 19 <u>55</u> , to <u>10 July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10 July</u> , 19 <u>55</u> , and that death occurred at <u>0905</u> M, from the causes and on the date stated above. SIGNATURE <u>Alfred E. Neale</u> ADDRESS (Street, city, town, state) <u>M.D. Fort G.G. Meade, Md.</u> DATE SIGNED <u>10 July 1955</u> <u>ALFRED E. NEALE, CAPT. MC</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10 July 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fort G.G. Meade, Maryland</u>	
24. REC'D BY REGISTRAR <u>W.L. SAYLOR, 1ST LT MSC</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chaplain White</u>		ADDRESS <u>Fort G.G. Meade, Md</u>	
DATE <u>10 July 1955</u>							

2075351291

CERTIFICATE OF DEATH

1. DEPARTMENT OF HEALTH - BALTIMORE 13

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF ASSISTANT

20. SIGNATURE OF CLERK

21. SIGNATURE OF RECEPTIONIST

22. SIGNATURE OF TELEPHONE OPERATOR

23. SIGNATURE OF MAIL ROOM

24. SIGNATURE OF RECORDS SECTION

25. SIGNATURE OF LABORATORY

26. SIGNATURE OF X-RAY DEPARTMENT

27. SIGNATURE OF RADIOLOGY

28. SIGNATURE OF PATHOLOGY

29. SIGNATURE OF BACTERIOLOGY

30. SIGNATURE OF VIROLOGY

31. SIGNATURE OF IMMUNOLOGY

32. SIGNATURE OF EPIDEMIOLOGY

33. SIGNATURE OF PUBLIC HEALTH

34. SIGNATURE OF COMMUNITY HEALTH

35. SIGNATURE OF SCHOOL HEALTH

36. SIGNATURE OF OCCUPATIONAL HEALTH

37. SIGNATURE OF ENVIRONMENTAL HEALTH

38. SIGNATURE OF NUTRITION

39. SIGNATURE OF PHYSICAL EDUCATION

40. SIGNATURE OF RECREATION

41. SIGNATURE OF ARTS AND CRAFTS

42. SIGNATURE OF MUSIC

43. SIGNATURE OF THEATRE

44. SIGNATURE OF FILM

45. SIGNATURE OF TELEVISION

46. SIGNATURE OF RADIO

47. SIGNATURE OF RECORDING

48. SIGNATURE OF PUBLISHING

49. SIGNATURE OF BOOKS

50. SIGNATURE OF PERIODICALS

51. SIGNATURE OF LIBRARIES

52. SIGNATURE OF MUSEUMS

53. SIGNATURE OF GALLERIES

54. SIGNATURE OF CONCERTS

55. SIGNATURE OF OPERAS

BUREAU V. S.

JUL 13 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06207

6209

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		13 yrs. 10 mos. 23 das.		TOWN <u>Baltimore</u>		3 Y 01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1606 McCulloh Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Ada Lane				July 26 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
F	Negro	Separated	Unknown	71?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laundress		Unknown		Maryland		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Richard Barton				Rebecca Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		Unknown		Hospital Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Bronchopneumonia - Myocardial Insufficiency</u>						3 days	
ANTECEDENT CAUSE(S) DUE TO (B) <u>AHCVD</u>						Known to us 9/3/41	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						Known to us since 9/3/41	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/31/48</u> , 19 <u>55</u> , to <u>7/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/25</u> , 19 <u>55</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>[Signature]</i>				Crownsville, Md.		7/26/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		7-29-55		MT. CALVARY CEM.		ANNE A. COUNTY Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>July 27, 1955</u>		<i>[Signature]</i>		<i>[Signature]</i>		<i>[Signature]</i>	

CERTIFICATE OF DEATH

MAINTAINED STATE OF VERMONT OF HEALTH-BALTIMORE, 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1870		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH	
100 N. Main St.		Farmer		Heart Disease		2 Weeks		JUL 28 1955		NEW YORK	
FATHER'S NAME		MOTHER'S NAME		MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE REGISTER		MARRIAGE OFFICIAL	
JAMES H. HARRIS		MARY J. HARRIS		JAN 15 1890		NEW YORK		JAMES H. HARRIS		JAMES H. HARRIS	
FATHER'S RESIDENCE		MOTHER'S RESIDENCE		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
100 N. Main St.		100 N. Main St.		Farmer		Farmer		JAN 15 1870		JAN 15 1870	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	

BUREAU V. I.

JUL 28 1955

RECEIVED

2001-10-10

1. The death of a person is a public event and the death certificate is a public document. It is the duty of the State to keep a record of the deaths of its citizens and to make this record available to the public. The death certificate is a document which is issued by the State to certify the death of a person. It is a document which is issued by the State to certify the death of a person. It is a document which is issued by the State to certify the death of a person.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06208

6210 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Crownsville</u>		<u>1 yr. 8 mos. 21 days</u>		TOWN <u>Baltimore City</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>10</u> <u>Crownsville State Hospital</u>				<u>562 Gold Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Spicer</u> (Middle) (Last) <u>Laws</u>				(Month) <u>7</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>Negro</u>	<u>Married</u>	<u>Unknown 12/24/88</u>	<u>66</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Unknown</u>		<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u>						<u>4 days</u>	
DUE TO ANTECEDENT CAUSE(S) (B) <u>Cerebral arteriosclerosis</u>						<u>Known to us</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes mellitus - Psychosis</u>						<u>since 10/20/53</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>2</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input checked="" type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/5</u> , 19 <u>55</u> , to <u>7/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/9</u> , 19 <u>55</u> , and that death occurred at <u>2:00a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edvard Heard Reisman</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>7/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE WHEREOF <u>7/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>mt. Auburn</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Thomas Kelso</u>		ADDRESS <u>1301 Preston St.</u>	
DATE <u>7-13-55</u>							

BUFILE - A - 1

JUL 13 1955

03 APR 1971

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06209

6211

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
X TOWN <u>Crownsville</u>		<u>8 1/2</u> hours		TOWN <u>Gaithersburg</u>		<u>15X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>10</u> <u>Crownsville State Hospital</u>				<u>Rte. #3</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Freeman</u> (Middle) <u>O.</u> (Last) <u>Lee</u>				(Month) <u>7</u> (Day) <u>6</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Unknown</u>	<u>6-27-25</u>	<u>30 1/2</u> yrs.	Months <u>-</u>	Days <u>-</u>	Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unknown Labor</u>		<u>Unknown</u>		<u>Unknown</u>		<u>Unk.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William O Lee</u>				<u>Helen Edmonia Swank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Unk.</u>				<u>Unk.</u>		<u>Add. info for Helen Lee</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Admitted 7/5/55</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>7/5/55</u>		<u>Coronary Occlusion</u>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		<u>M.</u>					
22. I hereby certify that I attended the deceased from <u>7/5/55</u> , 19 <u>55</u> , to <u>7/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/6</u> , 19 <u>55</u> , and that death occurred at <u>12:15</u> on <u>7/6</u> , 19 <u>55</u> , the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>L. Benedict</u>		<u>7-7-55</u>		<u>Mt E Zion</u>		<u>Rockville, Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Removal</u>		<u>K M X</u>		<u>Robert L. Snowden</u>		<u>Rockville Md</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Place of birth		6. Date of death	
7. Cause of death		8. Manner of death		9. Place of death	
10. Signature of physician		11. Signature of registrar		12. Date of registration	

BUREAU V. S.

JUL 11 1965

RECEIVED

NOTATION

06210

MARYLAND

STATE DEPARTMENT OF HEALTH

6212 CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> OR TOWN <u>Severna Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Severna Park</u> MD. OR TOWN <u>Severna Park</u> STREET ADDRESS (If rural, give location) <u>Cypress Creek Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>MARY Agnes Little</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>July 26</u> 19 <u>55</u> (Month) (Day) (Year)	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, <u>WIDOWED</u> DIVORCED, (Specify)	8. DATE OF BIRTH <u>Nov 27, 1904</u> 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Jesse Conway</u>		14. MOTHER'S MAIDEN NAME <u>Miss Violet Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Sons Wm. D. Little</u>		<u>1402 Woodbourne Ave.</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>MYOCARDIAL INFARCTION</u>		<u>30 min.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Generalized Arteriosclerosis - Hypertensive C.V. Disease 15 yrs</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
<u>Never saw alive</u>			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19..... and that death occurred at <u>8 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Robert R. Hahn</u>		ADDRESS <u>Severna Park Md</u>	
DATE SIGNED <u>July 26</u>		DATE SIGNED <u>July 26</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>July 29/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		LOCATION (City, town, or county) <u>Baltimore</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR <u>Ullrich Funeral Home</u>		ADDRESS <u>4210 Belair Road</u>	

MARGIN RESERVED FOR BINDING

Patient was under care of Dr. Martin Singewald, Balto.
Case has been passed by Dr. Jauherd - Med. Ex.

R.H.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6213

CERTIFICATE OF DEATH

06211

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>Byrs. 6 mos. 17 das.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Berlin</u>		<u>23 X - 2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Frank Lockwood</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 27 19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>43?</u> yrs.	IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u>	IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Lockwood</u>				14. MOTHER'S MAIDEN NAME <u>Clara Purnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>CVA</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Mental Deficiency (Moron)</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>-----</u>		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>-----</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>-----</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>-----</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-----</u>			
22. I hereby certify that I attended the deceased from <u>1/5</u> , 19 <u>55</u> , to <u>July 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/27</u> , 19 <u>55</u> , and that death occurred at <u>10:50 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>H. Cleary Heard Perrin</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>7/28/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>CEDAR CHAPEL</u>		LOCATION (City, town, or county) (State) <u>NEWARK MD</u>	
24. REC'D BY REGISTRAR DATE <u>Aug. 1, 1955</u>		REGISTRAR'S SIGNATURE <u>J. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>William Rees 108 W. Wash. ST Annapolis, Md.</u>			

CERTIFICATE OF DEATH

1955

MASSACHUSETTS

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

DATE OF DEATH

PLACE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. 8

AUG 2 1955

RECEIVED

Handwritten signature

MASSACHUSETTS

06212

MARYLAND STATE DEPARTMENT OF HEALTH

6214

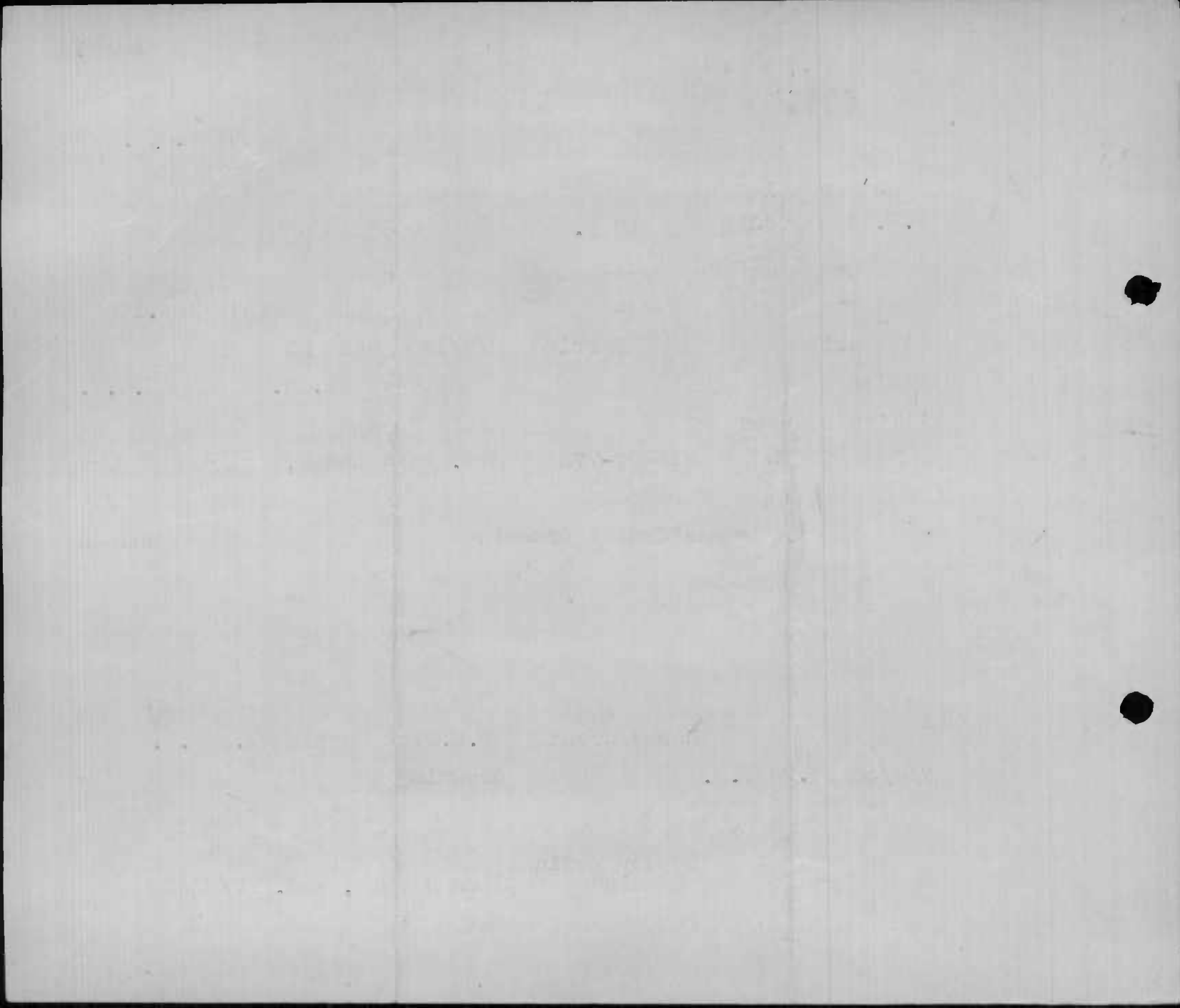
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 237

1. PLACE OF DEATH - COUNTY				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Anne Arundel</u> MARYLAND				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
TOWN <u>P.O. Glen Burnie</u> LENGTH OF STAY (In this place) <u>10 y.</u>				TOWN <u>Same</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Nabbs Creek</u>				STREET ADDRESS (If rural, give location) <u>Same</u>			
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)		5. SEX		6. COLOR OR RACE	
<u>James Edward Lucas</u>		<u>July 3rd 1955</u> 19		<u>Male</u>		<u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>8/9/1902</u>		9. AGE last birthday <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>	
11. BIRTHPLACE (State or foreign country) <u>Centreville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William N Lucas</u>		14. MOTHER'S MAIDEN NAME <u>Etta Frampton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-07-778</u>		17. INFORMANT AND ADDRESS <u>Mrs. Anna Lucas, (Mother)</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>929.8</u> Immediate cause (a) <u>Accidental Drowning</u>						<u>Sudden</u>	
Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Nabbs Creek</u>		(CITY OR TOWN) <u>P.O. Glen Burnie MD.</u> (COUNTY) <u>A.A.</u> (STATE) <u>02</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7/3/55 3.20 P.M.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Drowning</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <u>Gustave N. Pawlinski</u>		Deputy Medical Examiner <u>Glen Burnie, Md.</u>		DATE SIGNED <u>7/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7/6/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		LOCATION (City, town, or county) <u>G.A. Co.</u> (State) <u></u>	
DATE REC'D BY LOCAL REG. <u>7-5-55</u>		REGISTRAR'S SIGNATURE <u>Hedue Fleming</u>		FUNERAL DIRECTOR <u>Fleming</u>		ADDRESS <u>1476 Light St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06213

6715

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONV. HOME Route 2 Box 376A</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY _____ CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> STREET ADDRESS (If rural give location) <u>619 CARROLLTON AV.</u>			
3. NAME OF DECEASED (Type or Print) <u>GEORGE</u> (First) <u>MACK</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>7</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JAN. 3rd, 1884</u>	9. AGE last birthday <u>71</u> YRS.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>GRACE SMITH ALLEN, 252 MARION ST. BKLYN. N.Y. (3)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Constrictive heart failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May, 1955</u> , to <u>7/29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/26</u> , 19 <u>55</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph Taler</u>		M.D. <u>162 BALTO-AWAY A.P. BLDG. N.E. Glen Burnie, Md.</u>		DATE SIGNED <u>7/29/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>8/1/55</u>	NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cem</u>		LOCATION (City, town, or county) <u>Balto Md.</u> (State)			
24. REC'D BY REGISTRAR <u>8-1-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>512 Carrollton Av.</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED MARYLAND		DATE OF DEATH JAN. 21, 1934	
PLACE OF DEATH BALTIMORE		AGE 67	
RESIDENCE 610 CARROLLTON AV.		OCCUPATION CONSTRUCTION	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN W. S. SMITH		SIGNATURE OF REGISTRAR J. H. SMITH	
DATE OF REGISTRATION JAN. 22, 1934		PLACE OF REGISTRATION BALTIMORE	

NOTED BY THE REGISTRAR OF DEATHS
The above information was obtained from the death certificate filed with the Registrar of Deaths, Baltimore, Maryland, on January 22, 1934, and is being furnished to you for your information.

RECEIVED
AUG 1 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

6216

CERTIFICATE OF DEATH

06214

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>21</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u> <u>Solley Road</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u> <u>Solley Road</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Solley Road Md.</u>		STREET ADDRESS (If rural, give location) <u>Rt. # 1, Box 188</u>	
3. NAME OF DECEASED (Type or Print) <u>Frances</u> (First) (Middle) (Last) <u>Malecki</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 3</u> 19 <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-3-1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>74</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Lukapewski</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>217-09-1117</u>	
17. INFORMANT <u>Stanley James Malecki</u>		18. MEDICAL CERTIFICATION <u>Solley Road Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Anteromedial Cardio Vascular Disease</u> Antecedent cause(s) (b) <u>Coronary Artery Disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>5 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug.</u> , 19 <u>50</u> , to <u>July 3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/28</u> , 19 <u>55</u> , and that death occurred at <u>3 A.M.</u> , from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED <u>G. Brady Smith M.D.</u> <u>Riviera Beach, Md.</u> <u>7/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)	
DATE RECD BY LOCAL REG. <u>July 5, 1955</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u> FUNERAL DIRECTOR <u>John M. Weber</u> ADDRESS <u>401 S. Chester St</u>	

RECEIVED

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

MARYLAND

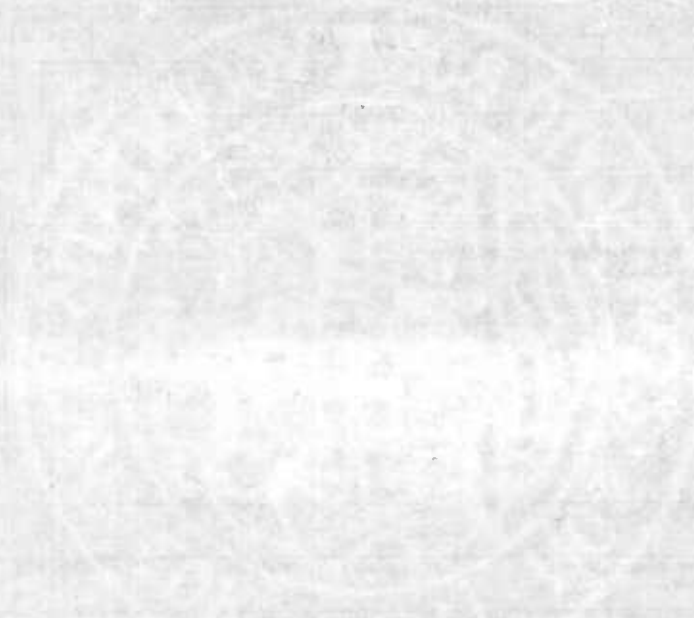
STATE DEPARTMENT OF HEALTH

6217 CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>M.D.</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Arundel Beach Rd</u>		STREET ADDRESS (If rural, give location) <u>Arundel Beach Rd</u>	
3. NAME OF DECEASED (First) <u>William</u> (Middle) <u>Henry</u> (Last) <u>Malone</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>3</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>July 24 1886</u> yrs. <u>68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret - carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
13. FATHER'S NAME <u>James J. Malone</u>		14. MOTHER'S MAIDEN NAME <u>Marie Brower</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Daughter Mrs Fear</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION <u>Arundel Beach Rd</u>	
Immediate cause <u>443X</u> (a) <u>Respiratory Failure</u>		INTERVAL BETWEEN ONSET AND DEATH	
Antecedent cause(s) <u>Generalized arteriosclerosis</u> (b) <u>Hypertensive Cardio Vascular Disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Coronary Insufficiency</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>Coronary Insufficiency</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		(CITY OR TOWN) (COUNTY) (STATE)	
22. I hereby certify that I attended the deceased from <u>Dec</u> , 19 <u>54</u> , to <u>July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2 July</u> , 19 <u>55</u> , and that death occurred at <u>6:30 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>R. Hahn</u> (Degree or title) <u>M.D.</u>		ADDRESS <u>Severna Park Md.</u> DATE SIGNED <u>July 55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> DATE <u>7/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>New Providence</u> LOCATION (City, town, or county) <u>Dorsey Md.</u> (State)	
DATE REC'D BY LOCAL REG. <u>5-55</u> REGISTRAR'S SIGNATURE <u>A.W. Kline</u>		24. FUNERAL DIRECTOR <u>Cook Inc.</u> ADDRESS <u>1217 St. Paul St</u>	

MARGIN RESERVED FOR BINDING



6218

CERTIFICATE OF DEATH

Reg. Dist. No.

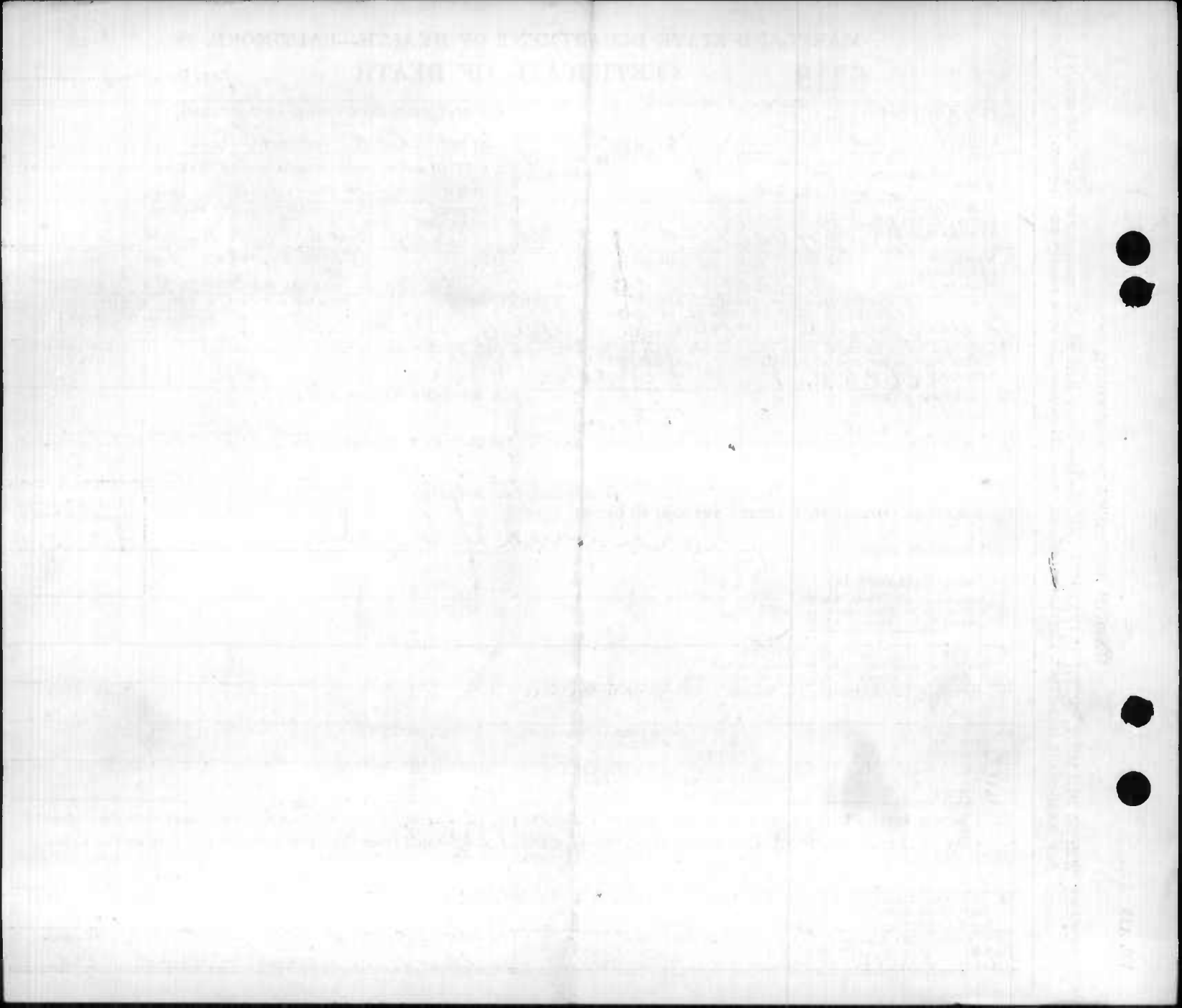
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>X Hanover, Md.</i>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>X Hanover</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Box 462 Hanover, Md.</i>				STREET ADDRESS (If rural, give location) <i>Box 462 Hanover, Md.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Samuel Eugene Matthews</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>July 22, 1955</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>Colored</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married June 6, 1906</i>		8. DATE OF BIRTH: <i>June 6, 1906</i>	
9. AGE last birthday: <i>55</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Merchant</i>		11. BIRTHPLACE (State or foreign country): <i>Hanover, Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Elias Matthews</i>				14. MOTHER'S MAIDEN NAME: <i>Price</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Mrs. Maggie L. Matthews Box 462 Hanover, Md.</i>	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>181X Carcinoma of Bladder</i>	<i>9 mo.</i>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	
(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <i>Jan. 1st, 1951</i> , to <i>July 22nd, 1955</i> , that I last saw the deceased alive on <i>July 21st, 1955</i> , and that death occurred at <i>12:30 a.m.</i> , from the causes and on the date stated above.	
SIGNATURE <i>Frank Shipley, M.D.</i>	DATE SIGNED <i>7/22/55</i>
23. BURIAL, CREMATION REMOVAL (Specify): <i>Burial</i>	DATE THEREOF <i>July 24, 1955</i>
NAME OF CEMETERY OR CREMATORY <i>St. Rest</i>	LOCATION (City, town, or county) (State) <i>Hanover, Md.</i>
DATE REC'D BY LOCAL REGISTAR'S SIGNATURE <i>July 23 1955 R.W.</i>	24. FUNERAL DIRECTOR <i>Funeral Home 1631 Druid Hill Ave.</i>

MARGIN RESERVED FOR BINDING



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06217

6219

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>DAVIDSONVILLE</u>		<u>48 yrs</u>		TOWN <u>Davidsonville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		RFD		STREET ADDRESS		(If rural give location)	
00				RFD		/	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>JOSEPH</u> <u>ANTON</u> <u>MAYR</u>				<u>JULY</u> <u>31</u> , <u>1955</u> ₁₉			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Feb. 19, 1871</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Ret. Farmer</u>		<u>Owned Farm</u>		<u>Germany</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>none</u>		<u>Mr. Thomas E. Mayr- Son- Same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
433.1 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
DUE TO <u>Conjunctive Heart Failure</u>						<u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B)						<u>6 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)						<u>1 year</u>	
<u>Arteriosclerosis</u>						<u>10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>None</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
				<u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>none</u>		<u>M.</u>					
22. I hereby certify that I attended the deceased from <u>July 26, 1955</u>, to <u>July 31, 1955</u>, that I last saw the deceased alive on <u>July 31, 1955</u>, and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Garbus E. Garcon</u> M.D.				<u>Upper Marlboro, Md. 7-31-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>August 3, 1955</u>		<u>Our Lady of Sorrows Cemet.</u>		<u>OWENSVILLE, A.A. Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>August 1, 1955</u>		<u>Carrie Smith</u>		<u>HOPKINS FUNERAL HOME</u>		<u>ANNAPOLIS, MD.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

445

• FLOCK:

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

BUREAU

AUG 4 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

06218

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 24.

1. PLACE OF DEATH - COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Virginia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) P.O. Pasadena		CITY (If outside corporate limits, write RURAL and give nearest town) Alexandria	
TOWN P.O. Pasadena LENGTH OF STAY (In this place) Few seconds		TOWN Alexandria 83X.3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Woods near Grammar School of High Point.		STREET ADDRESS (If rural, give location) 1420 Dogwood Drive	
3. NAME OF DECEASED (Type or Print) Lud James Milisterff		4. DATE OF DEATH July 19 1955	
5. SEX Male		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 8/18/18	
9. AGE last birthday 36 yrs.		10. BIRTHPLACE (State or foreign country) Bison, S.D.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Major in the U.S.A. Air Forces		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Milisterff		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) Air Forces, presently.		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS U.S. Air Force Records, Capt. J.R. Finn			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Charred and mutilated beyond recognition		Sudden
Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		PLACE (Home, farm, factory, street, OF office bldg., etc.) In the air	(CITY OR TOWN) High Point P.O. Pasadena, A.A.	(COUNTY) Maryland.
TIME (Month) (Day) (Year) (Hour) OF INJURY 7/19/55 12.30 P.M.	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? Collision in the air.		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

 Deputy Medical Examiner
Glen Burnie, Md.

DATE SIGNED

7/20/55

23. BURIAL, CREMATION (Type or Print) Buried	DATE THEREOF 21 July 1955	NAME OF CEMETERY OR CREMATORY Arle. Natl. Cem.	LOCATION (City, town, or county) Arle. Va.	(State)
DATE REC'D BY LOCAL REG. July 20, 1955	REGISTRAR'S SIGNATURE R. J. De Alba	24. FUNERAL DIRECTOR Funeral Home	ADDRESS 816 - H St N.E. Wash. D.C.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3.

JUL 22 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06219

6168

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>ANNAPOLIS</u>		<u>1 1/2 hr.</u>		TOWN <u>Baltimore</u>		<u>23 3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hosp Franklin ST</u>				STREET ADDRESS (If rural give location) <u>406 S. Payson ST.</u> ✓			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Nolan Franklin Miller</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 30 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV 21-1915</u>	9. AGE, last birthday <u>39</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Work</u>		11. BIRTHPLACE (State or foreign country) <u>York Penna</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHARLES F. MILLER</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE Faringher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>CATHERINE B. MILLER 406 S. Payson ST</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
825X IMMEDIATE CAUSE (A) <u>MULTIPLE Severe Accidental Injuries</u>						<u>1 Hr 30 Min</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>STREET</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Jones Station Ritchie Highway</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>9:30 PM JULY 30 55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>AUTO ACCIDENT</u>			
22. I hereby certify that I attended the deceased from <u>30 JULY</u> , 19 <u>55</u> , to <u>30 JULY</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>30 JULY</u> , 19 <u>55</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. E. Landmesser Jr</u>				ADDRESS (Street, city, town, state) <u>96 Cathedral Annapolis Md</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Aug 3-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Houdon Park</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>PHILIP B. Walters</u>		ADDRESS <u>PHILIP STRICKER ST</u>	
DATE							

2

6169

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

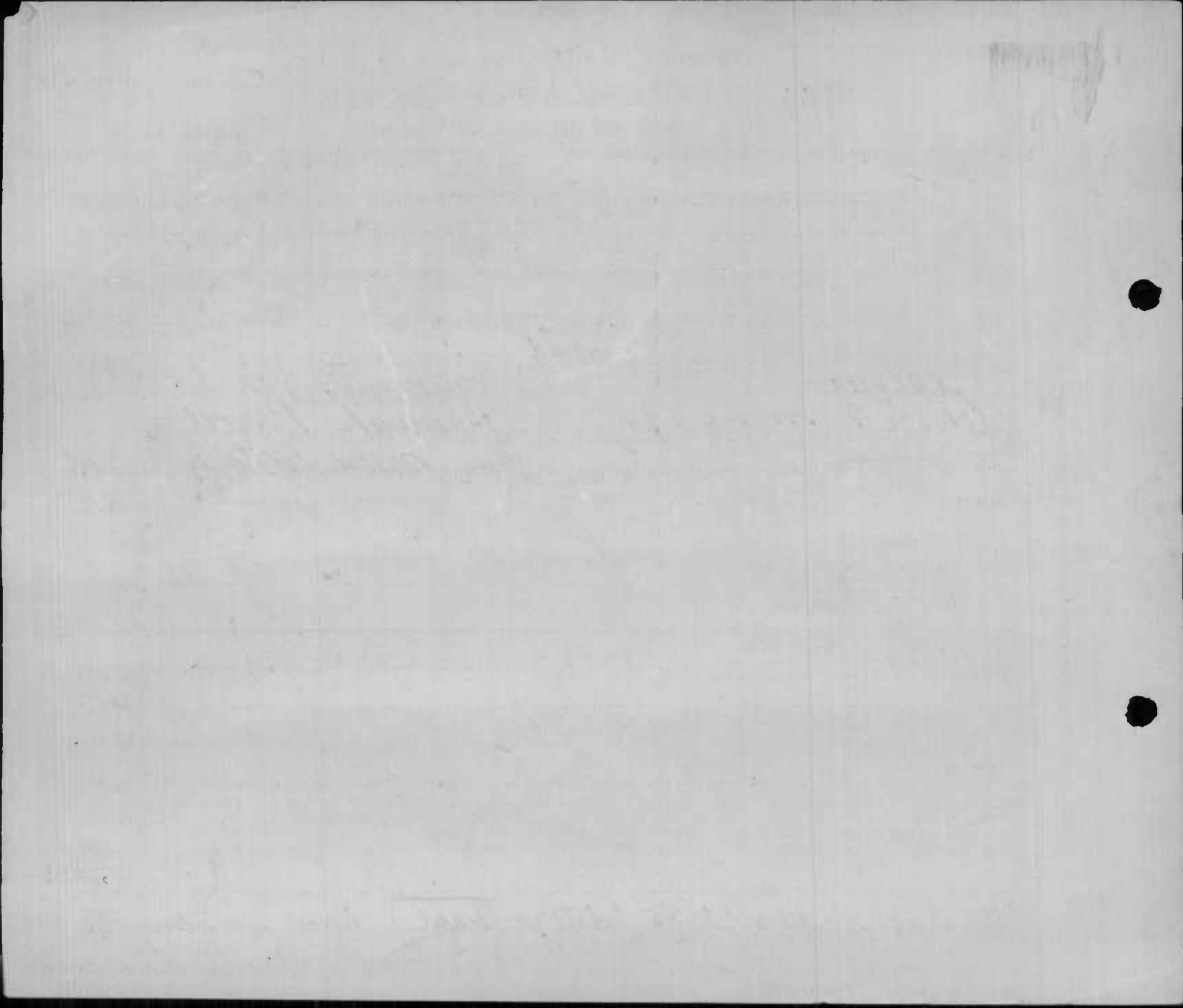
06220

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Annapolis</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u> 10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>		STREET ADDRESS (If rural, give location) <u>33 Hutton Place</u> 1	
3. NAME OF DECEASED (Type or Print) <u>OLIVER</u>	(First) (Middle) (Last) <u>MORSE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 25 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED; (Specify) <u>Married</u>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>38</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Westminster, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver S. Morse, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Powell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Oliver S. Morse, Westminster Md</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cardiac tamponade due to stab wound of chest</u>			
Antecedent cause(s) (b) <u>involving myocardium</u>			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death. <u>Coronary occlusion; Myocardial infarct</u>			
19a. DATE OF OPERATION <u>2</u>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>home of friend</u>	(CITY OR TOWN) <u>Annapolis</u> (COUNTY) <u>Anne Arundel</u> (STATE) <u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7/25/55 12:45 A.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Stabbed with knife during altercation</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>William Updegraff</u>		ADDRESS <u>701 E. 4th St.</u>	
DATE SIGNED <u>July 26, 1955</u>			
23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>July 30 55</u>	NAME OF CEMETERY OR CREMATORY <u>Western Chapel</u>	LOCATION (City, town, or county) (State) <u>Rural, Westminster Md</u>
DATE REC'D BY LOCAL REG. <u>7-27-55</u>	REGISTRAR'S SIGNATURE <u>J. S. Morse, Jr.</u>	24. FUNERAL DIRECTOR <u>Westminster Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6222
CERTIFICATE OF DEATH

06222

Reg. Dist. No. 23

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Anne Arundel	MARYLAND	STATE Maryland	COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN P.O. Glen Burnie	LENGTH OF STAY (in this place) 30 y.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Margate Drive		STREET ADDRESS Margate Drive	
3. NAME OF DECEASED: (First) (Middle) (Last) George Henry Neubeck		4. DATE OF DEATH: (Month) (Day) (Year) July 20th 1955	
5. SEX: M	6. COLOR OR RACE: W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 1/9/93
		9. AGE last birthday: 62 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Carpenter		10b. KIND OF BUSINESS OR INDUSTRY: self-employed	11. BIRTHPLACE (State or foreign country): Baltimore, Md.
13. FATHER'S NAME: Joseph Neubeck		14. MOTHER'S MAIDEN NAME: ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY No.: 217-16-0042	
		17. INFORMANT & ADDRESS: Mrs. M. Neubeck, (Wife) Margate Dr. Glen Burnie.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
163X Immediate cause (a) Carcinoma of lungs		5 months
Antecedent causes (s) (b) Infection of lungs		?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)		

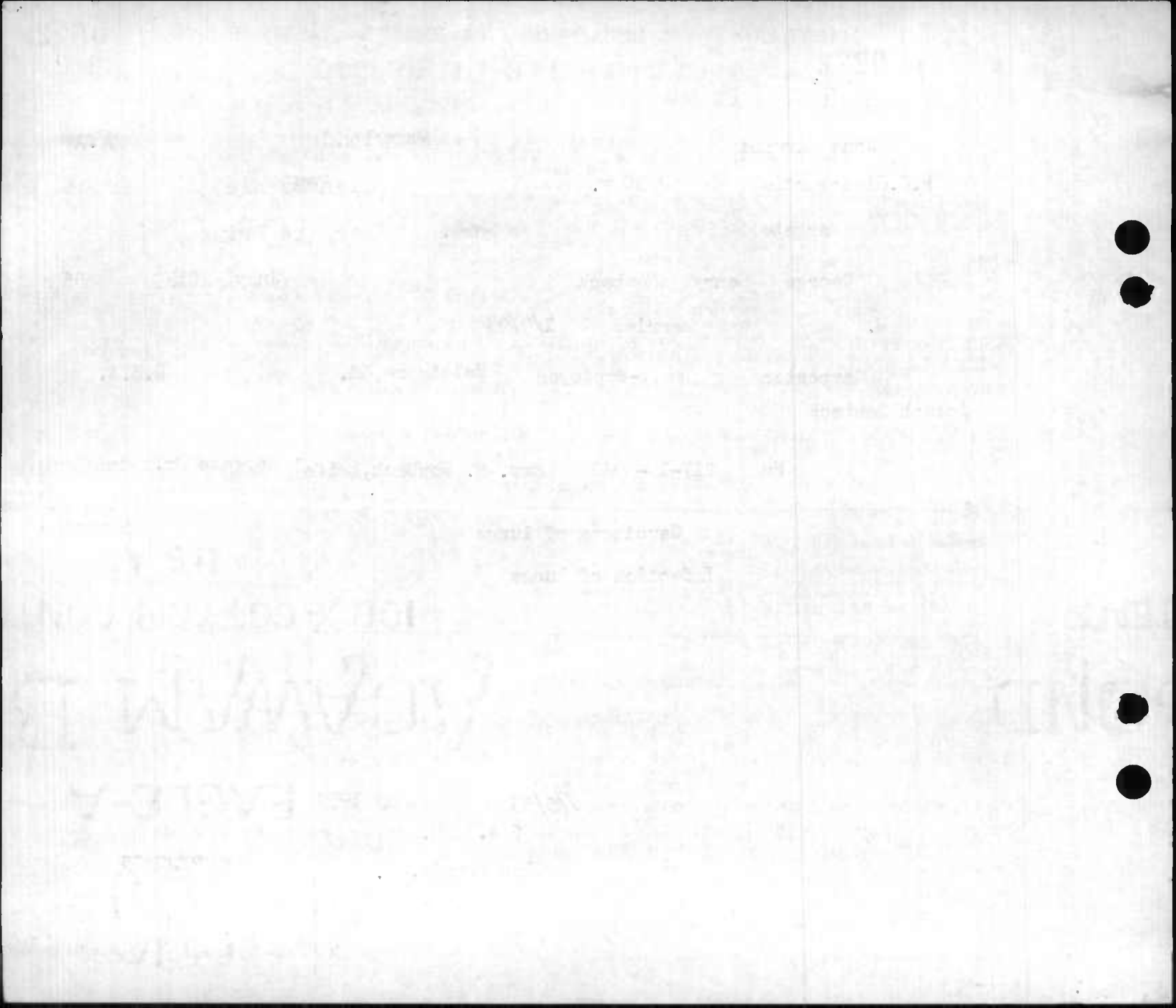
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION: May 1955	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **2/5/55**, 19....., to **May 1955**, 19....., that I last saw the deceased alive on **May**, 1955, and that death occurred at **5 A. M.**, from the causes and on the date stated above.

SIGNATURE Ernest H. Beecher		DATE SIGNED 7/20/55	
ADDRESS Glen Burnie, Md.			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	July 23, 1955	Loudon Park	Balto. Md.
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
3277	Geo. J. Gonce	4001 Ritchie Hwy	Balto 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

06221

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>Mo.</u>		COUNTY <u>A.A.Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>RIVA</u>				TOWN <u>RIVA</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 RIVERVIEW Nursing Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>ELIZABETH D. Nott</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7 28 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>12/25/1898</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>DAVENPORT Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT Nott</u>				14. MOTHER'S MAIDEN NAME <u>ETHEL MASON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>MRS WALLACE #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
450.0 IMMEDIATE CAUSE (A) <u>pericarditis</u>						<u>20 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>catatonic stupor</u>						<u>4-5 yrs.</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 45</u> , 19 <u>45</u> , to <u>July 28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 27</u> , 19 <u>55</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>J. Brown</u> M.D.				ADDRESS (Street, city, town, state) <u>Campanolis Mo 7128157</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		DATE THEREOF <u>7/28/55</u>		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
						<u>DAVENPORT Iowa</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. O. Daniel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Campanolis Mo</u>	
DATE <u>7/29/55</u>							

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6223

CERTIFICATE OF DEATH

06223

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>New York</u>		COUNTY <u>Monroe</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Fort George G. Meade</u>		<u>2 1/2 Yrs.</u>		TOWN <u>Rochester</u>		<u>69X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>357 West Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>STEPHEN MICHAEL NOWAK</u>				<u>July 3 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>3 July 1955</u>	<u>Yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Alfred Theodore Nowak</u>				<u>Beverley Mass</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>Alfred Theodore Nowak</u> <u>Father, 504 S. Lehigh Street, Balt. 24.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Premature</u>						INTERVAL BETWEEN ONSET AND DEATH <u>50 Minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>0255-3 July 19 55</u>, to <u>0345-3 July 19 55</u>, that I last saw the deceased alive on <u>3 July 19 55</u>, and that death occurred at <u>0345 A.M.</u>, from the causes and on the date stated above.							
SIGNATURE <u>Alfred E. Neale</u> M.D.				ADDRESS (Street, city, town, state) <u>Fort G. G. Meade, Maryland</u>			
				DATE SIGNED <u>July 3, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal-permission granted to remove remains to Second Army Med Lab, FPGM, Md.</u>							
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>W.L. Saylor, 1st LT MSC</u>				<u>None</u>			
DATE <u>7 July 1955</u>							

2075216210

CERTIFICATE OF DEATH

BUREAU V. 2

12 1955

RECEIVED

NO RECORDING OR INDEXING OF THIS DOCUMENT IS REQUIRED BY THE NATIONAL ARCHIVES OF THE UNITED STATES GOVERNMENT

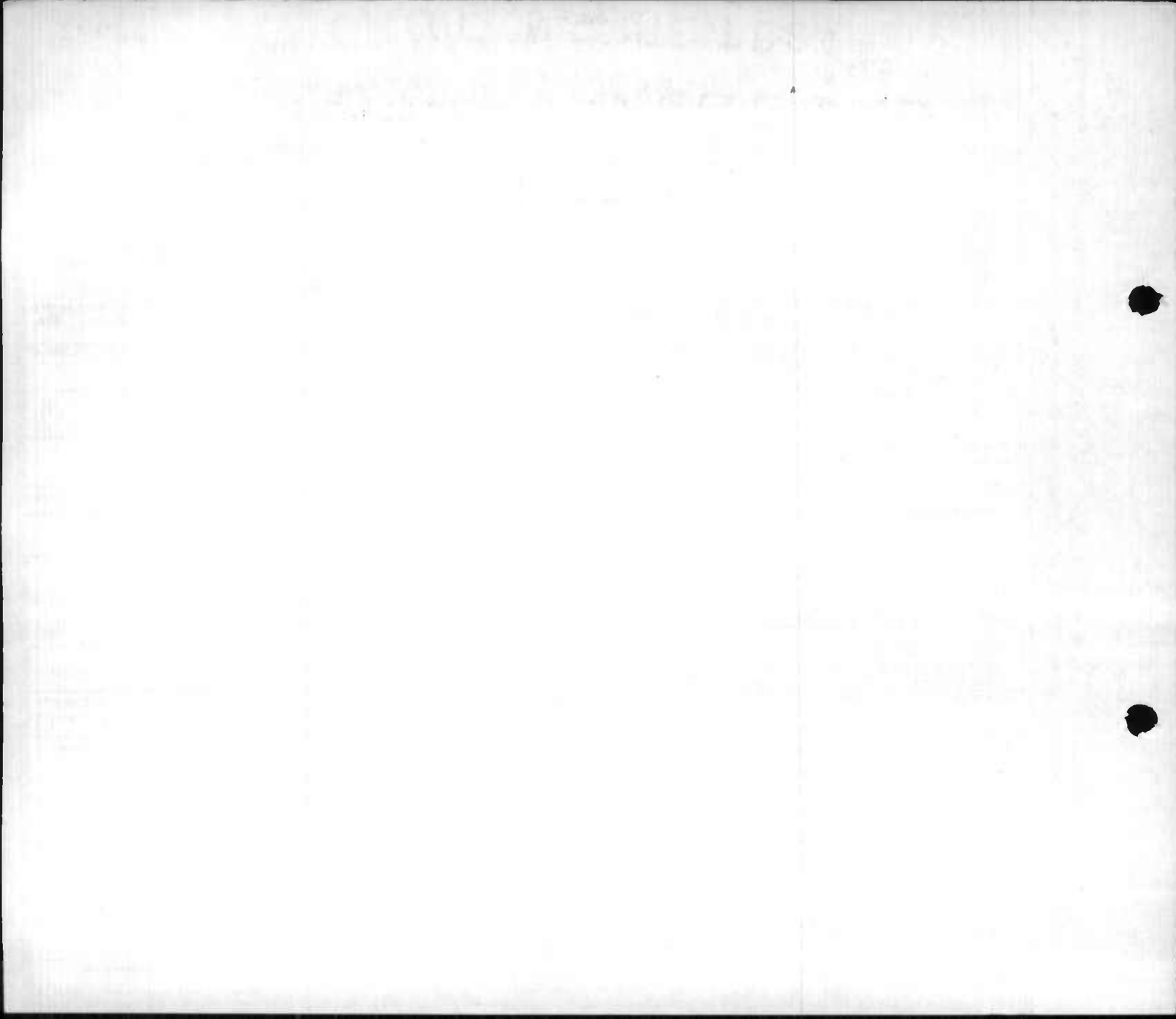
6224

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) JOHN O'BRIEN			2. DATE OF DEATH 7/8/55		
3. PLACE OF DEATH: A. Baltimore City, Maryland X a. a. P.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Fort Meade 50			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 3Y01-4		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1305 Wildwood Parkway		
5. SEX M	6. COLOR OR RACE W	7. SINGLE MARRIED. WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct 26 1907		9. AGE (In years last birthday) 47
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier C. V. O.		10B. KIND OF BUSINESS OR INDUSTRY U.S. Air Force		11. BIRTHPLACE (State or foreign country) Mass	
13. FATHER'S NAME Frank O'Brien			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes W. W. #2			16. SOCIAL SECURITY NO.		17. INFORMANT Wm Brennan Wildwood Pkwy

AL CERTIFICATION	18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC CARDIO		INTERVAL BETWEEN ONSET AND DEATH	
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUETO VASCULAR DISEASE	
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) Acute myocardial infarction -	
			(C) posterior left ventricle & septum	
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and found that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
23A. SIGNATURE Paul F. Meri		23B. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER M.D. MEDICAL INVESTIGATOR		23C. DATE SIGNED 7/9/55
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal	24B. DATE 7/11/55	24C. NAME OF CEMETERY OR CREMATORY Franklinham	24D. LOCATION (City, town, or county) Mass.	(State)
DATE RECEIVED BY LOCAL REGISTRAR 7-11-55	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR Wm. Bork Inc. 1217 St. Paul St		ADDRESS



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6225

CERTIFICATE OF DEATH

06225

Reg. Dist. No. 21

INSTRUCTIONS

1 The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A155 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Robinson</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Robinson</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>Martha (First) (Middle) (Last) Pack</i>		<i>July 9 19 55</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov 4 1881</i>
9. AGE last birthday <i>74</i> yrs.		10. IF UNDER 1 YEAR <i>0</i> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Armstrong A.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Robert Wallace</i>		14. MOTHER'S MARDEN NAME <i>Mary G. Jennings</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <i>James Earl Pack</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
159X IMMEDIATE CAUSE (A) <i>Concussion / G.D. Fract</i>		INTERVAL BETWEEN ONSET AND DEATH <i>about 2 mos.</i>	
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<i>0</i>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<input type="checkbox"/>		<i>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?	
<i>7-7-55</i>		<i>6-2 Caught in</i>	
22. I hereby certify that I attended the deceased from <i>7-7-55</i> to <i>7-9-55</i>, 19 <i>55</i>, that I last saw the deceased alive on <i>7-7-55</i>, 19 <i>55</i>, and that death occurred at <i>11:54</i> A.M. from the causes and on the date stated above.			
SIGNATURE <i>J.T. Allen</i>		ADDRESS (Street, city, town, state) <i>62 Cathedral St Robinson Md</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>buried July 12</i>		24. REC'D BY REGISTRAR <i>U. Council</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>J.B. Johnson</i>		ADDRESS <i>Armstrong</i>	

CERTIFICATE OF DEATH

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

1. MEDICAL CERTIFICATION

2. MEDICAL CERTIFICATION

3. MEDICAL CERTIFICATION

4. MEDICAL CERTIFICATION

5. MEDICAL CERTIFICATION

6. MEDICAL CERTIFICATION

7. MEDICAL CERTIFICATION

8. MEDICAL CERTIFICATION

9. MEDICAL CERTIFICATION

10. MEDICAL CERTIFICATION

11. MEDICAL CERTIFICATION

12. MEDICAL CERTIFICATION

BUREAU V. E.

JUL 14 1965

RECEIVED

AMORTIZATION

AMORTIZATION is the process of paying off a loan or investment over time. It involves making regular payments that cover the principal amount and the interest. The process is used for various types of loans, including mortgages, car loans, and business loans. The amortization schedule shows the amount of each payment, the portion that goes towards the principal, and the portion that goes towards the interest. The total amount paid over the life of the loan is the sum of all payments. The amortization process is essential for understanding the cost of borrowing and for planning financial resources.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06226

6170 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR TOWN) <u>10 Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL OR TOWN) <u>10 Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Homewood Convalescent</u>				STREET ADDRESS <u>173 Green St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JAMES PAVLEROS</u>				<u>July 20 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>About 24</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if (Specify) <u>Refractioner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Candy</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Themestocles Pavleros</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>same as #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Acute Pulmonary Edema & Arricular Fibrillation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic C.V. Disturbance</u>						<u>Yes</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Mid-thigh amputation 1 mo ago due to arterial embolism</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 8:10P</u> , 19 <u>52</u> , to <u>7/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/20</u> , 19 <u>55</u> , and that death occurred at <u>8:10P</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Maurice H. Lawans, M.D.</u>		DATE SIGNED <u>7/24/55</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-25-55</u>		NAME OF CEMETERY OR CREMATORY <u>Greek Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>110 J. J. J. J.</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
DATE <u>7/22/55</u>							

CERTIFICATE OF DEATH

Form No. 10-58

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF OTHER

16. SIGNATURE OF OTHER

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

31. SIGNATURE OF OTHER

32. SIGNATURE OF OTHER

33. SIGNATURE OF OTHER

34. SIGNATURE OF OTHER

35. SIGNATURE OF OTHER

36. SIGNATURE OF OTHER

37. SIGNATURE OF OTHER

38. SIGNATURE OF OTHER

39. SIGNATURE OF OTHER

40. SIGNATURE OF OTHER

41. SIGNATURE OF OTHER

42. SIGNATURE OF OTHER

43. SIGNATURE OF OTHER

44. SIGNATURE OF OTHER

45. SIGNATURE OF OTHER

46. SIGNATURE OF OTHER

47. SIGNATURE OF OTHER

48. SIGNATURE OF OTHER

49. SIGNATURE OF OTHER

50. SIGNATURE OF OTHER

51. SIGNATURE OF OTHER

52. SIGNATURE OF OTHER

53. SIGNATURE OF OTHER

54. SIGNATURE OF OTHER

55. SIGNATURE OF OTHER

56. SIGNATURE OF OTHER

57. SIGNATURE OF OTHER

BUREAU Y. B.

JUL 25 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6171
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 21

06227

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>A.A. Co.</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>a.a.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	OR TOWN
10 TOWN <i>Annapolis</i>		<i>Edgewater</i>	<i>X</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural, give location)
63 <i>A.A. Gen. Hosp</i>			<i>/</i>
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Thomas</i>	(Middle) <i>L.</i>	(Last) <i>Petrie</i>	(Month) <i>7</i> (Day) <i>7</i> (Year) <i>19 55</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>7-5-1887</i>
			9. AGE last birthday: <i>68</i> yrs.
10. USUAL OCCUPATION (Give kind of work done during most of work life, or if retired):		11. BIRTHPLACE (State or foreign country):	
<i>Retired U.S. Public Institute</i>		<i>Pennsylvania</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>James Petrie</i>		<i>Bridgett Palmer</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no, or unk.)		16. SOCIAL SECURITY No.:	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
		<i>Isabelle M. Palmer Edgewater Md.</i>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
4343 Immediate cause (a) <i>Heart Disease</i>			<i>Sudden</i>
DUE TO			
Antecedent cause(s) (b) <i></i>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
DUE TO			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>E. H. Smith</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>7/7/55</i>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		M. D. ASSISTANT MEDICAL EXAM. <i>Robert A. Mattingly</i>	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>July 8, 1955</i>	<i>July 11, 1955</i>	<i>Arlington National</i>	<i>Arlington Va.</i>
DATE REC'D BY LOCAL REG.	REGISTERING SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>July 8, 1955</i>	<i>J. J. Daniel</i>	<i>Robert A. Mattingly</i>	<i>131-11th St. S.E. Washington D.C.</i>

COMMUNICATIONS SECTION

RECEIVED JUL 19 1955

BUREAU V. B.

JUL 19 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06228

6228

CERTIFICATE OF DEATH

Item 4, Film G188 10-21-55 et

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Dorchester</i>		<i>26 yrs</i>		TOWN <i>Dorchester, Md</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>Dorchester</i>				<i>Dorchester</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Rachael</i> (Middle) <i>Pindell</i> (Last)				(Month) <i>July</i> (Day) <i>26</i> (Year) <i>19 55</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>F</i>	<i>C</i>	<i>widow</i>	<i>1871</i>	<i>84</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<i>MD.</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Mose Rawlings</i>				<i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<i>Estelle Della, Davidsonville, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<i>443X</i> IMMEDIATE CAUSE (A) <i>hypertensive Cardio-vascular Disease</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7-29-55</i> to <i>7-26-55</i> , that I last saw the deceased alive on <i>7-25-55</i> , 19 <i>55</i> , and that death occurred at <i>5:45</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>G. T. Carr</i>				ADDRESS (Street, city, town, state) <i>M.D. 62 Cathedral St. Davidsonville, MD</i>		DATE SIGNED <i>7-27-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>7/29/55</i>		<i>Union</i>		<i>Davidsonville, MD</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Gaugher</i>		<i>Carrie Smith</i>		<i>Bernard Hardisty, Leesville Rd</i>			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

06229

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>a a</u>	
CITY OR TOWN <u>Chalk Point, West River</u>		LENGTH OF STAY (in this place) <u>40 years</u>		CITY OR TOWN <u>Chalk Point, West River</u>		STREET ADDRESS (If rural give location) <u>md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>							
3. NAME OF DECEASED (Type or Print) <u>Maggie P. Placide</u>				4. DATE OF DEATH (Month) <u>7</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>July 17 1867</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Chalk Pt West River md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Kuebler</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Knapp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Balt md</u> <u>Dudley Placide</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE (A) <u>Pulmonary Congestion</u>						<u>10 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive failure</u>						<u>4 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>						<u>seventy years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>pneumonia 5 mos ago.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>55</u> , to <u>21 July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>21 July</u> , 19 <u>55</u> , and that death occurred at <u>4:45 P</u> .M. from the causes and on the date stated above.							
SIGNATURE <u>F. H. Hendricks</u> M.D.				ADDRESS (Street, city, town, state) <u>Shady Side, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>7/25/55</u>		NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		LOCATION (City, town, of county) (State) <u>Galesville md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. J. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hendricks</u>		ADDRESS <u>Galesville md</u>	
DATE <u>7-25-55</u>							

6228

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Bodkin's Creek LENGTH OF STAY (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Baltimore City
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 301-4
 STREET ADDRESS (If rural, give location) 2610 Allendale Rd.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

CharlesRylandPollard

4. DATE OF DEATH:

(Month)

(Day)

(Year)

DEATH:

July719 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MaleWhiteMarriedFeb. 22, 187877

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Sales Mgr.ResearchBaltimore, Md.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Charles R. PollardNancy Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

No216-12-3912 AKatherine M. Pollard - 2610 Allendale Rd.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1

Immediate cause

(a)

Cardio-vascular disease

DUE TO

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c)

Arterio-sclerosis

INTERVAL BETWEEN ONSET AND DEATH

about 8 mo

11. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 16, 1954, to July 7, 1955, that I last saw the deceased alive on July 5, 1955, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

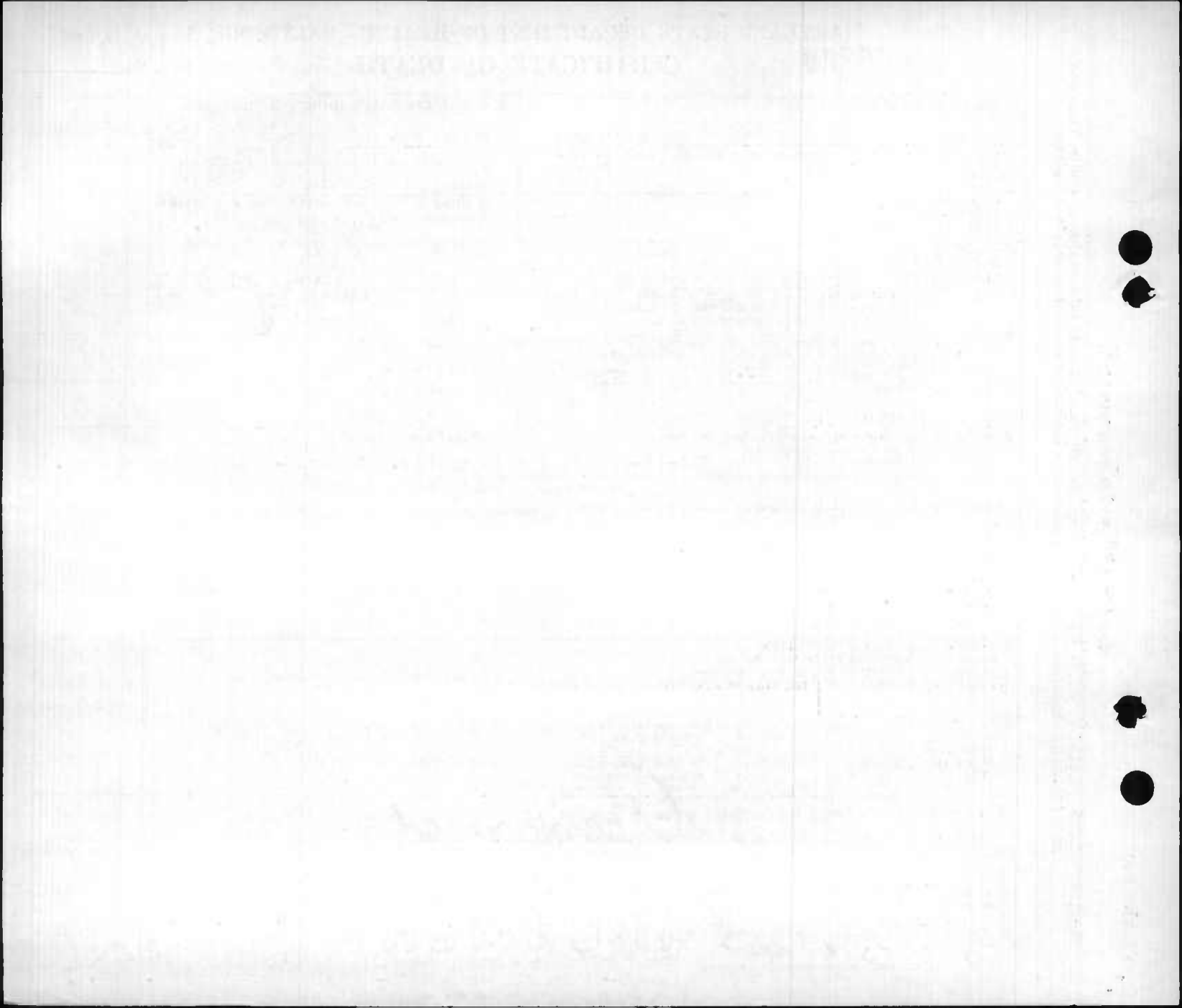
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7-8-55Ellsworth ArmacostEllsworth ArmacostmdEllsworth Armacost - 4600 Liberty Hghts. Ave. 7

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH

06231

6229

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 23

1. PLACE OF DEATH - CITY (if outside corporate limits, write RURAL and give nearest town) TOWN <u>Glen Burnie</u>		CITY (if outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Furnace Creek</u>		STREET ADDRESS <u>1114 W. Pratt St.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Robert J. RAHE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7/8/55</u> <u>19</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>4/24/35</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. Steel</u>	9. AGE last birthday <u>20</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Rahe</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Dahl</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mrs Katherine Rahe</u>		<u>1114 W. Pratt St.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
<p>9298</p> <p>Immediate cause (a) <u>Accidental Drowning,</u> Sudden</p> <p>Antecedent cause(s) (b) _____</p> <p>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____</p>		

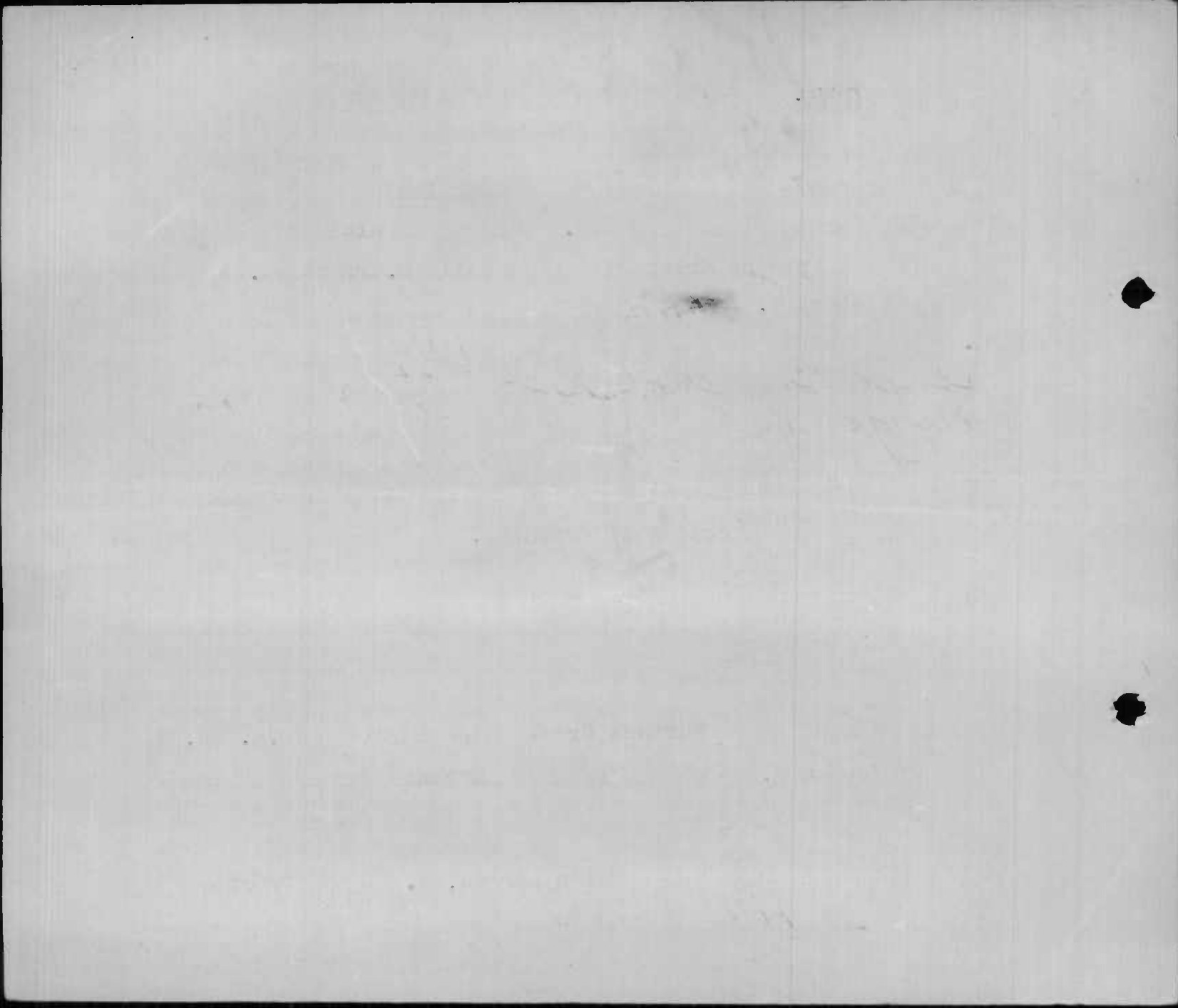
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or place where injured) <u>Furnace Creek</u>	(CITY OR TOWN) <u>Glen Burnie</u> (COUNTY) <u>A.A. Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7/8/55</u> <u>5 A.</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Drowning</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>Donald H. Pouchard</u>		(Degree or title)	ADDRESS <u>Glen Burnie, Md.</u>	DATE SIGNED <u>7/8/55</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>7/11/55</u>	NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>	LOCATION (City, town, or county) (State) <u>Edmondson & Longwood</u> <u>Sts.</u>	
DATE RECEIVED BY LOCAL REG. <u>7/8/55</u>	REGISTRAR'S SIGNATURE <u>John J. Cowan</u>	FUNERAL DIRECTOR <u>John J. Cowan</u>	ADDRESS <u>916 Hallis</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07374

6230

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Crownsville</u>		<u>1 mo. 11 days</u>		TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>125 Prague Court</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Levi Ramsey</u>				<u>July 27 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>Negro</u>	<u>Unknown</u>	<u>Unknown</u>	<u>74</u> yrs.	Months <u>—</u>	Days <u>—</u>	Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unknown</u>		<u>—</u>		<u>Unknown</u>		<u>Unknown</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unknown</u>		<u>Unknown</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>002X</u> IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Known to us since 6/16/55</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
<u>0026X</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CNS Syphilis</u>						<u>Known to us since 6/16/55</u>	
<u>Chronic Brain Syndrome Associated with Arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 16</u> , 19 <u>55</u> , to <u>July 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 27</u> , 19 <u>55</u> , and that death occurred at <u>3:45 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Richard Heard Ramsey</u>				ADDRESS (Street, city, town, state) DATE SIGNED <u>1/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>8/11/55</u>		<u>8/11/55</u>		<u>St. Agnes Cemetery</u>		<u>Baltimore Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>8-13-55</u>		<u>A. M. Joyce</u>		<u>Francis A. Joyce</u>		<u>578 W. 10th St.</u>	

1955

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

693

28

1. NAME OF DECEASED		2. SEX		3. AGE	
JAMES EARL RAY		MALE		35	
4. DATE OF DEATH		5. PLACE OF DEATH		6. CAUSE OF DEATH	
AUGUST 19, 1955		BALTIMORE, MARYLAND		HEART DISEASE	
7. SIGNATURE OF PHYSICIAN		8. SIGNATURE OF REGISTRAR		9. SIGNATURE OF WITNESSES	
[Signature]		[Signature]		[Signatures]	
10. PLACE OF BIRTH		11. OCCUPATION		12. MARITAL STATUS	
MEMPHIS, TENNESSEE		MEMBER OF CONGRESS		MARRIED	
13. PREVIOUS RESIDENCE		14. PREVIOUS ADDRESS		15. PREVIOUS PHONE	
BALTIMORE, MARYLAND		1234 MAIN ST.		555-1234	
16. PREVIOUS EMPLOYER		17. PREVIOUS EMPLOYMENT		18. PREVIOUS EMPLOYMENT	
U.S. HOUSE OF REPRESENTATIVES		MEMBER OF CONGRESS		MEMBER OF CONGRESS	
19. PREVIOUS EMPLOYMENT		20. PREVIOUS EMPLOYMENT		21. PREVIOUS EMPLOYMENT	
U.S. HOUSE OF REPRESENTATIVES		MEMBER OF CONGRESS		MEMBER OF CONGRESS	
22. PREVIOUS EMPLOYMENT		23. PREVIOUS EMPLOYMENT		24. PREVIOUS EMPLOYMENT	
U.S. HOUSE OF REPRESENTATIVES		MEMBER OF CONGRESS		MEMBER OF CONGRESS	
25. PREVIOUS EMPLOYMENT		26. PREVIOUS EMPLOYMENT		27. PREVIOUS EMPLOYMENT	
U.S. HOUSE OF REPRESENTATIVES		MEMBER OF CONGRESS		MEMBER OF CONGRESS	
28. PREVIOUS EMPLOYMENT		29. PREVIOUS EMPLOYMENT		30. PREVIOUS EMPLOYMENT	
U.S. HOUSE OF REPRESENTATIVES		MEMBER OF CONGRESS		MEMBER OF CONGRESS	

BUREAU V. 2

AUG 19 1955

RECEIVED

Richard Howard Kinnear

8-13-55

SHORT-DEFINITION

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6231

CERTIFICATE OF DEATH

06232

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Crownsville</u>		<u>2 yr. 10 mos. 22 days</u>		TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Unknown</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>John W. Rice</u>				<u>7 21 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Separated</u>	<u>Unknown</u>	<u>76?</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None listed</u>		<u>- - -</u>		<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME <u>Sam Rice</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No.</u>		<u>Unknown</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Myocardial Insufficiency</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Arteriosclerotic Cardiovascular Dis.</u>						<u>Known to us since 8/29/52</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Senile Psychosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>- -</u>		<u>- - -</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>- -</u>		<u>- - -</u>		<u>- - -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>- -</u>		<u>M.</u>		<u>- - - -</u>			
22. I hereby certify that I attended the deceased from <u>8/29</u>, 19 <u>52</u>, to <u>7/21</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>7/21</u>, 19 <u>55</u>, and that death occurred at <u>4:30a</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D.		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>7/21, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>[Signature]</u>		<u>7/25/55</u>		<u>university medical school</u>		<u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>7-26-55</u>		<u>R. M. Joyce</u>		<u>Francis A. Hensley</u>		<u>578 W. Biddle</u>	

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
John Doe		35		Male	
Residence		Occupation		Cause of Death	
123 Main St, Baltimore, MD		Teacher		Heart Disease	
Date of Death		Place of Death		Time of Death	
July 20, 1955		Home		10:30 AM	
Physician		Medical Examiner		Burial	
Dr. J. Smith		Dr. A. Jones		St. Mary's Cemetery	
Signature of Physician		Signature of Medical Examiner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]	

BUREAU V. 1

JUL 29 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 23

6232

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Balts. City</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL OR TOWN)	(If rural give location)
<i>X</i> TOWN <i>Glen Burnie</i>	<i>10 mo</i>	<i>Baltimore</i>	<i>3601-4</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
<i>90</i> <i>Plaza Manor Nursing Home</i>		<i>869 W. Fayette St</i>	
3. NAME OF DECEASED: (Type or Print)	(First) (Middle) (Last)	4. DATE OF DEATH:	(Month) (Day) (Year)
<i>LILLIAN</i>	<i>RICHARDSON</i>	<i>July 7</i>	<i>1955</i>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<i>F</i>	<i>Col.</i>	<i>Wid.</i>	<i>Oct. 1887</i>
9. AGE last birthday:	10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<i>67</i> yrs.	<i>housewife</i>	<i>Princeton N.C.</i>	<i>yes. USA</i>
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY No.:
<i>Charles Royal</i>	<i>Lillie</i>	<i>no</i>	<i>Hettie</i>

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<i>446 X</i>		
Immediate cause		
(a)	<i>Uremia</i>	<i>7 days</i>
DUE TO		
Antecedent causes (s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		
(b)	<i>Chronic nephritis & pyelitis</i>	<i>1 yr</i>
DUE TO		
(c)	<i>Arteriosclerotic vascular-renal disease</i>	<i>10 yrs</i>
11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
<i>Right-sided hemiplegia</i>		<i>1 1/2 yrs</i>
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY ?
<i>none</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg. etc.)	(CITY OR TOWN) (COUNTY) (STATE)
<i>none</i>		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED	HOW DID INJURY OCCUR?
	White at Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	

22. I hereby certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at *10:45 PM*, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

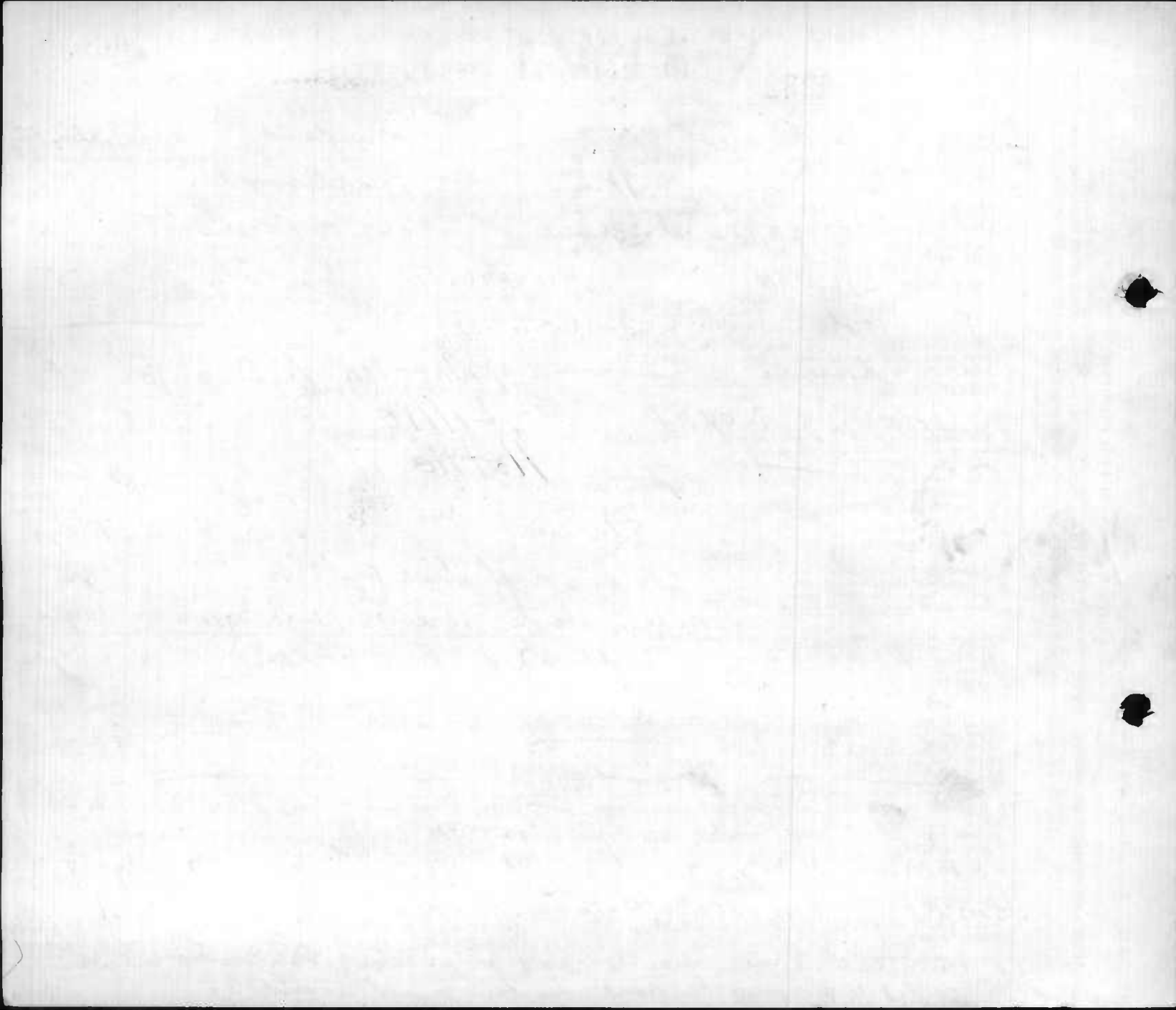
H. F. Manuzak M.D. *901 Edgerly Rd. Glen Burnie, Md.* *7 July 1955*

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Removal</i>	<i>7/11/1955</i>	<i>Arundel Memorial</i>	<i>Arundel Md.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>7-11-55</i>		<i>Mrs. Kater R. Williams</i>	<i>Schneider St</i>

Note: this patient has been under the care of Dr. J. J. Taler of Glen Burnie & I was called to pronounce her dead when he was not available.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06234

6233

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>GARLAND PARK</u>		STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>GARLAND PARK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>400 BROADVIEW BLVD.</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location)		<u>400 BROADVIEW BLVD</u>	
3. NAME OF DECEASED (Type or Print) <u>CHARLES A. RINGES</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 18 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCTOBER 22, 1892</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OUT OF LOCAL</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM RINGES</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>MRS AGNES L. RINGES, GARLAND PARK, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>CARDIAC DECOMPENSATION</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>7/16</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAY 2, 1955</u>, to <u>7/18, 1955</u>, that I last saw the deceased alive on <u>7/16, 1955</u>, and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert L. Jones MD</u>		DATE THEREOF <u>7/21/55</u>		NAME OF CEMETERY OR CREMATORY <u>WESTERN CEMETERY</u>		LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>	
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR <u>Dr. C. L. Woodruff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Inc.</u>		ADDRESS <u>1247 ST. PAUL ST.</u>	
DATE <u>7/19/55</u>							

CERTIFICATE OF DEATH

Form No. 1

DEPARTMENT OF HEALTH

STATE OF MARYLAND

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

MANNER OF DEATH

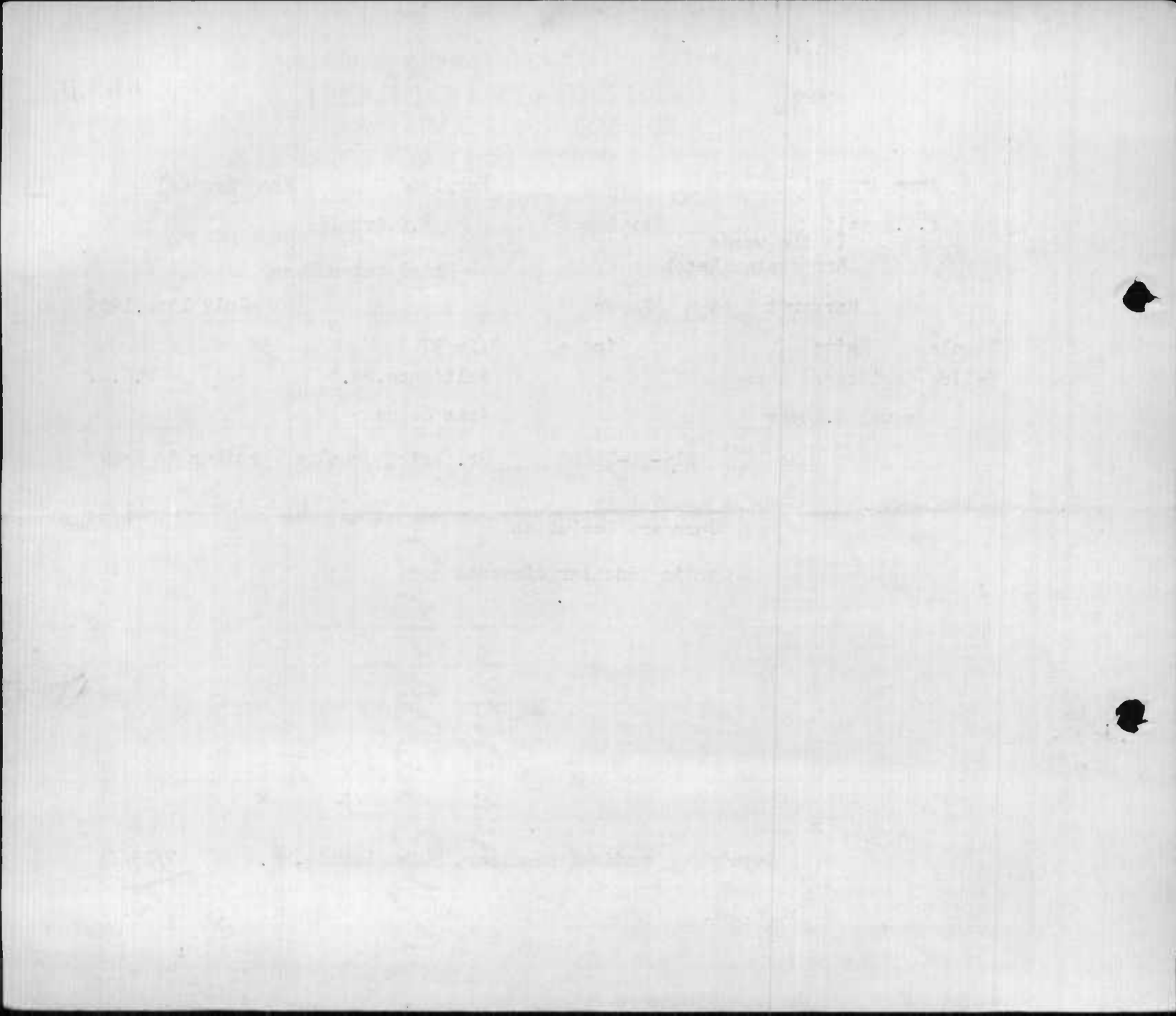
EDUCATION

RELIGION

SMOOTHED

10

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Anne Arundel		Maryland	
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN P.O. Arnold		TOWN P.O. Arnold	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
In the woods		(If rural, give location)	
Broadwater Beach		Broad water Beach	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
Margaret Ann Royer		July 13th. 1955 19	
5. SEX		6. COLOR OR RACE	
Female		White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
Single		3/26/97	
9. AGE last birthday		10. BIRTHPLACE (State or foreign country)	
58 yrs.		Baltimore, Md.	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
U.S.A.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Samuel A. Royer		Anna Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
No		219-30-7666	
17. INFORMANT		18. MEDICAL CERTIFICATION	
Mr. Erick Scholtz (brother in law)		1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
420.1		(a) Coronary Occlusion	
Immediate cause		(b) Cardio vascular diseases	
Antecedent cause(s)		(c)	
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
		Sudden	
		?	
11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .	
TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		SIGNATURE	
		Deputy Medical Examiner, Glen Burnie, Md.	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
Burial		July. 16. 55	
NAME OF CEMETERY OR CREMATOR		LOCATION (City, town, or county) (State)	
Meadowbranch Cem		Westminister Md.	
DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR ADDRESS	
7-15-55		HENRY SANDER & SONS. INC.	
REGISTRAR'S SIGNATURE		Baltimore Md.	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6235

06236

Reg. Dist. 21

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN		3v01-4	
TOWN <u>BURRILL</u>		<u>visiting</u>		STREET ADDRESS (If rural, give location)		<u>2625 Hudson St</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>General Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JAMES HENRY SANDS</u>				<u>7 10 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>WIDOWED</u>	<u>4/20/1888</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>LABORER</u>		<u>CITY OF BALTO</u>		<u>MARYLAND</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>THOMAS SANDS</u>				<u>MARY E - ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
		<u>—</u>		<u>MRS. IDA R. SANDS, 2625 Hudson St</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>420.1</u>		<u>Coronary disease</u>		<u>Sudden</u>	
Immediate cause		(a) DUE TO			
Antecedent cause(s)		(b) DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.					
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
<u>John L. Loefer</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7-10-55			
		ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>7/14/55</u>		<u>ST. STANISLAUS</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>7-13-55</u>		<u>John Loefer</u>		<u>M. F. JADOWSKI, 1808 EASTERN AVE</u>	

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

REPORT OF THE SPECIAL AGENT IN CHARGE

TO THE DIRECTOR, BUREAU OF LAND MANAGEMENT

FROM THE SPECIAL AGENT IN CHARGE

DATE OF REPORT

REPORT NO.

PROJECT NO.

LOCATION

DESCRIPTION OF PROJECT

OBJECTIVES

METHODS

RESULTS

CONCLUSIONS

RECOMMENDATIONS

APPENDICES

REFERENCES

ACKNOWLEDGMENTS

DISTRIBUTION STATEMENT

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06237

6238

CERTIFICATE OF DEATH

Reg. Dist. No.

Crownsville State Hospital

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Md.</u>		COUNTY <u>Balti</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		<u>2 days</u>		TOWN <u>Baltimore</u> <u>21</u>		<u>03-54-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1609 Hopewell Ave.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lonnie</u> <u>Saunders</u>				<u>July</u> <u>27</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Negro</u>	<u>single</u>	<u>unknown</u>	<u>10</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>unknown</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>237X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hyperpyrexia (Temp. 110o)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Brain Tumor</u>						<u>1 yr.(?)</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Idiot</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/25</u> , 19 <u>55</u> , to <u>7/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/27</u> , 19 <u>55</u> , and that death occurred at <u>1:15 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>Hidegard Heard</u>				DATE SIGNED <u>7/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEROF <u>7-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	
				LOCATION (City, town, or county) <u>Baltimore Md.</u>		(State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>7-29-55</u>		<u>Arthur</u>		<u>Elroy A. Wilson</u>		<u>Baltimore Md.</u>	

CERTIFICATE OF DEATH

Form 10-55

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESS

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

BUREAU V. S.

AUG 2 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06238

6237

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND CITY OR TOWN <u>Rural - Glen Burnie</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>611 Binsted Rd</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George's</u> CITY OR TOWN <u>Rural - Glen Burnie</u> STREET ADDRESS <u>611 Binsted Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna</u> <u>Crimes</u> <u>Schneider</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>6</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan 13, 1887</u>
9. AGE last birthday <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Crimes</u>		14. MOTHER'S MAIDEN NAME <u>Emma Eugenia Jacobs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S ADDRESS <u>611 Binsted Rd, Glen Burnie, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
260X IMMEDIATE CAUSE (A) <u>Pulmonary Congestion</u>		<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>		<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus</u>		<u>15 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Obesity</u>		<u>15 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>7/6</u> , 19 <u>55</u> , to <u>7/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/6</u> , 19 <u>55</u> , and that death occurred at <u>7:45</u> P.M., from the causes and on the date stated above.	
SIGNATURE <u>Richard</u> M.D.		ADDRESS (Street, city, town, state) <u>715 Cotton Rd, Baltimore</u> DATE SIGNED <u>7/6/55</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/9/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>L. J. DeAlba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Kirkley</u> ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>	
DATE <u>July 8, 1955</u>			

CERTIFICATE OF DEATH

Form No. 10-58

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

BUREAU V. 5

JUN 11 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06239

6172

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>ANNAPOLIS</u>		<u>4 1/2 yrs</u>		TOWN <u>Annapolis,</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>30 Bloomsbury Sq.</u>				STREET ADDRESS (If rural give location) <u>30 Bloomsbury Sq</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARY SEARS</u>				<u>JULY 24, 1955</u> 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days)	IF UNDER 24 HRS. (Hours) (Min.)	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>July 9, 1911</u>	<u>44 yrs.</u>	<u>0</u> <u>15</u>	<u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House wife</u>		<u>own home</u>		<u>Annapolis, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Wilson</u>				<u>Mary Agnes Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>None</u>		<u>Mr. Bernard E. Sears; Husband: # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>153X</u> IMMEDIATE CAUSE (A) <u>Inanition</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Metastatic Carcinoma of Colon</u>						<u>18 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>February 19, 53</u> , to <u>July 24, 55</u> , that I last saw the deceased alive on <u>July 24, 55</u> , and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Edward A. Beck</u>		<u>July 26, 55</u>		<u>Cedar Bluff Cemetery</u>		<u>Annapolis, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		DATE SIGNED	
<u>Burial</u>		<u>7-25-55</u>		<u>4- [Signature]</u>		<u>7/25/55</u>	
				HOPPING FUNERAL HOME		ANNAPOLIS, MD.	

00180

REPUBLICAN STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

MD 100-100

1. NAME OF DECEASED

John A. Smith

2. SEX

Male

3. RACE

White

4. DATE OF BIRTH

Jan 1, 1900

5. PLACE OF BIRTH

Baltimore, Md

6. OCCUPATION

Teacher

7. DATE OF DEATH

Dec 1, 1955

8. PLACE OF DEATH

Baltimore, Md

9. CAUSE OF DEATH

Heart Disease

10. SIGNATURE OF PHYSICIAN

John A. Smith

11. SIGNATURE OF REGISTRAR

John A. Smith

12. SIGNATURE OF WITNESS

John A. Smith

13. DATE OF INTERVIEW

Dec 1, 1955

14. PLACE OF INTERVIEW

Baltimore, Md

15. CAUSE OF DEATH

Heart Disease

16. SIGNATURE OF PHYSICIAN

John A. Smith

17. SIGNATURE OF REGISTRAR

John A. Smith

18. SIGNATURE OF WITNESS

John A. Smith

19. DATE OF INTERVIEW

Dec 1, 1955

20. PLACE OF INTERVIEW

Baltimore, Md

21. CAUSE OF DEATH

Heart Disease

22. SIGNATURE OF PHYSICIAN

John A. Smith

23. SIGNATURE OF REGISTRAR

John A. Smith

24. SIGNATURE OF WITNESS

John A. Smith

25. DATE OF INTERVIEW

Dec 1, 1955

26. PLACE OF INTERVIEW

Baltimore, Md

27. CAUSE OF DEATH

Heart Disease

28. SIGNATURE OF PHYSICIAN

John A. Smith

29. SIGNATURE OF REGISTRAR

John A. Smith

30. SIGNATURE OF WITNESS

John A. Smith

31. DATE OF INTERVIEW

Dec 1, 1955

32. PLACE OF INTERVIEW

Baltimore, Md

33. CAUSE OF DEATH

Heart Disease

34. SIGNATURE OF PHYSICIAN

John A. Smith

35. SIGNATURE OF REGISTRAR

John A. Smith

36. SIGNATURE OF WITNESS

John A. Smith

37. DATE OF INTERVIEW

Dec 1, 1955

38. PLACE OF INTERVIEW

Baltimore, Md

39. CAUSE OF DEATH

Heart Disease

40. SIGNATURE OF PHYSICIAN

John A. Smith

41. SIGNATURE OF REGISTRAR

John A. Smith

42. SIGNATURE OF WITNESS

John A. Smith

43. DATE OF INTERVIEW

Dec 1, 1955

44. PLACE OF INTERVIEW

Baltimore, Md

45. CAUSE OF DEATH

Heart Disease

46. SIGNATURE OF PHYSICIAN

John A. Smith

47. SIGNATURE OF REGISTRAR

John A. Smith

48. SIGNATURE OF WITNESS

John A. Smith

49. DATE OF INTERVIEW

Dec 1, 1955

50. PLACE OF INTERVIEW

Baltimore, Md

51. CAUSE OF DEATH

Heart Disease

52. SIGNATURE OF PHYSICIAN

John A. Smith

53. SIGNATURE OF REGISTRAR

John A. Smith

54. SIGNATURE OF WITNESS

John A. Smith

55. DATE OF INTERVIEW

Dec 1, 1955

56. PLACE OF INTERVIEW

Baltimore, Md

57. CAUSE OF DEATH

Heart Disease

BUREAU V. 2

JUL 26 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6238

CERTIFICATE OF DEATH

06240

28

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town.)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		<u>5yrs. 8mos. 28das.</u>		TOWN <u>Baltimore</u>		<u>3y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Unknown</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>John Slater</u>				<u>July 25 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>Negro</u>	<u>Married</u>	<u>Unknown</u>	<u>70?</u> yrs.	Months <u>---</u>	Days <u>---</u>	Hours <u>---</u> Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jim Slater</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>491X</u> IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile Psychosis</u>				<u>Known to us since 11/28/49</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<u>0</u>		<u>-----</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>-----</u>		<u>-----</u>		<u>-----</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>-----</u>		<u>M. at work</u>		<u>-----</u>			
22. I hereby certify that I attended the deceased from <u>7/5/55</u> , 19... <u>55</u> , to <u>7/25/</u> , 19... <u>55</u> , that I last saw the deceased alive on <u>7/25</u> , 19... <u>55</u> , and that death occurred at <u>4:30pm</u> , from the causes and on the date stated above.							
SIGNATURE <u>Cherett W. Cadenhead, M.D.</u>				ADDRESS (Street, city, town, state) <u>Crownsville State Hosp. Crownsville Md.</u>		DATE SIGNED <u>7-26-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>-----</u>		<u>7/28/55</u>		<u>University School of Medicine</u>		<u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>7-29-55</u>		<u>K. M. Joyce</u>		<u>Francis A. Hensley</u>		<u>3rd</u>	
DATE							

BUREAU V. S.

AUG 2 1955

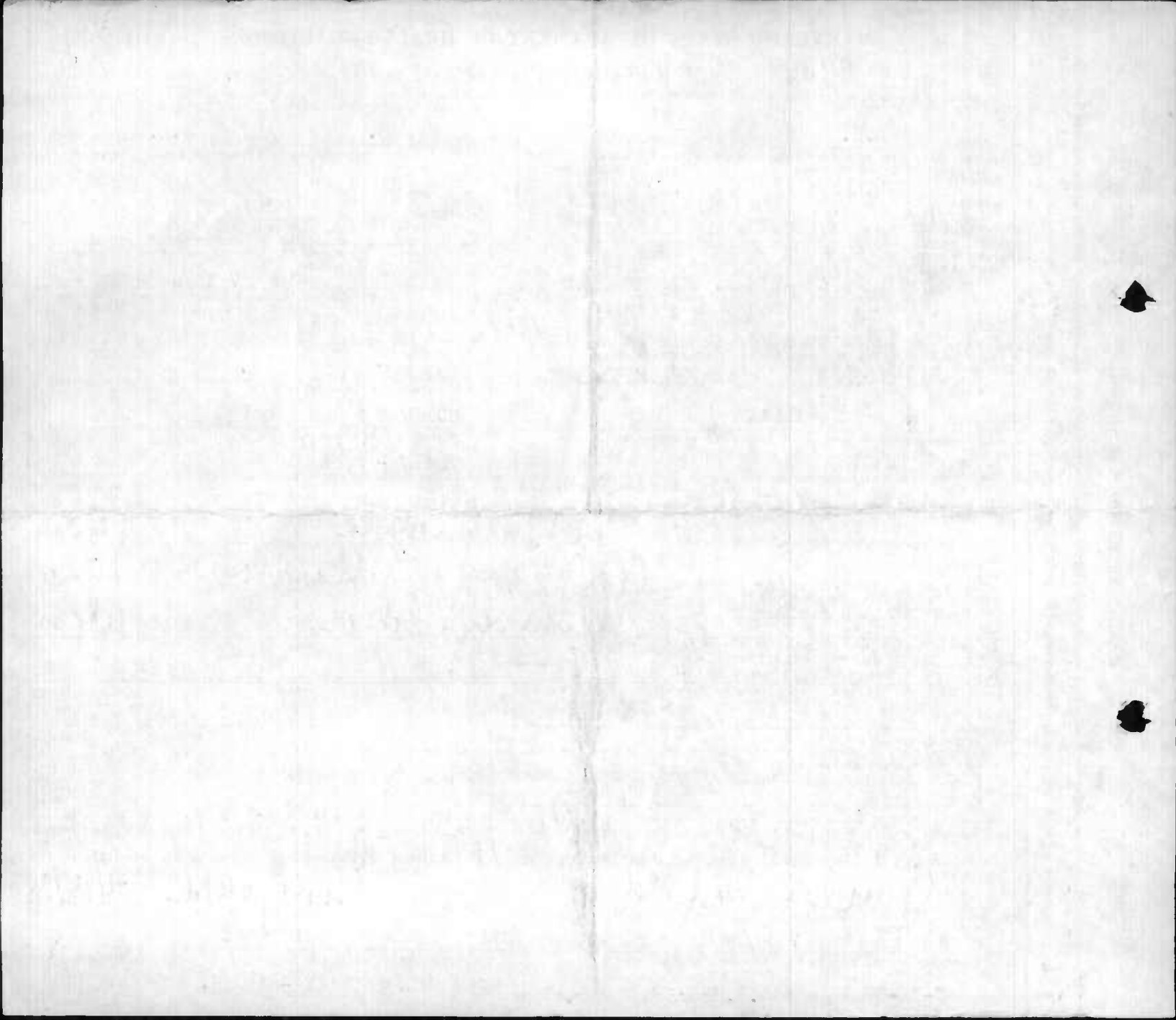
RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06241
6239 CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY A.A.	MARYLAND	STATE MD.	COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) 50 TOWN BROOKLYN	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 50 BROOKLYN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 07 318 CRESSWELL ROAD		STREET ADDRESS (If rural give location) 1 318 CRESSWELL ROAD	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
CHARLIE A. SMIDDY		DEATH: 7/14/55 19	
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): M	8. DATE OF BIRTH: 1/19/57
9. AGE last birthday 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FOREMAN		10B. KIND OF BUSINESS OR INDUSTRY: BROWN DISTILLERS	
11. BIRTHPLACE (State or foreign country): KENTUCKY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: WILLIAM		14. MOTHER'S MAIDEN NAME: LUCIENDA PARKS	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL FORCES? (Yes, no, or unk.) 4 NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: FAMILY - SAME			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 002X			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Cox Pulmonary			1 Year
(B) Pulmonary Tuberculosis			1 Year
(C) Pulmonary Fibrosis			1 Year
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Had , 19 55 , to July 14 , 19 55 , that I last saw the deceased alive on July 13 , 19 55 , and that death occurred at 9 A M, from the causes and on the date stated above.			
SIGNATURE Paul Schufeldt		DATE SIGNED 7/15/55	
M. D. 2301 Annapolis Rd			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) B		DATE THEREOF 7/18/55	
NAME OF CEMETERY OR CREMATORY CEDAR HILL		LOCATION (City, town, or county) (State) BALTIMORE	
DATE REC'D BY LOCAL REGISTRAR 7-15-55		REGISTRAR'S SIGNATURE A.W. Hedrich dmr.	
24. FUNERAL DIRECTOR JAMES L. MCCULLY - 130 E. FORT AVENUE		ADDRESS	



6240

CERTIFICATE OF DEATH

Reg. Dist. No. 28

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>4 mos. 22 days</u>		CITY OR TOWN <u>Baltimore City</u>		3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>779 George Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mollie</u> <u>Smith</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7</u> <u>7</u> <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>73?</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Alfred Smith</u>				14. MOTHER'S MAIDEN NAME <u>Georgianna Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>026x</u> IMMEDIATE CAUSE (A) <u>Central Nervous System Syphilis</u>				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>Known to us since 2/15/55</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Generalized Arteriosclerosis</u> (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>- - - - -</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/15/55</u> , 19 <u>55</u> , to <u>7/7/</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/7/</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Hildegard Heard</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>			
DATE SIGNED <u>7/8/55</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7/12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS <u>578 W. Biddle St.</u>	
DATE							

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Manner of Death		Signature of Physician	
Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
Date of Burial		Place of Burial		Signature of Minister	
Date of Inquest		Place of Inquest		Signature of Jury	
Date of Autopsy		Place of Autopsy		Signature of Pathologist	
Date of Exhumation		Place of Exhumation		Signature of Coroner	
Date of Reinterment		Place of Reinterment		Signature of Minister	
Date of Cremation		Place of Cremation		Signature of Crematorium	
Date of Disposition		Place of Disposition		Signature of Disposer	
Date of Return		Place of Return		Signature of Returner	
Date of Final Disposition		Place of Final Disposition		Signature of Final Disposer	

BUREAU V. B.

JUL 13 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06243

CERTIFICATE OF DEATH

Reg. Dist. No. 21

6173

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>10</u> TOWN <u>Annapolis</u> LENGTH OF STAY (in this place) <u>74 1/2</u> Yrs.				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>10</u> TOWN <u>Annapolis</u> STREET ADDRESS (If rural give location) <u>1</u> <u>29 Monument Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>WILLIAM HENRY STEPNEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 5, 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>November 16, 1879</u>		9. AGE last birthday <u>75</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer-Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WILLIAM HENRY STEPNEY SR.</u>				14. MOTHER'S MAIDEN NAME <u>HENRIETTA JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>5-8-1899* 9-10-1899</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>William Vaughn Stepney-36 Washington St Annapolis, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic Hypertension</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiovascular disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>6 months</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>July 4, 19 55</u> to <u>July 5, 19 55</u> , that I last saw the deceased alive on <u>July 4, 19 55</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above. <u>7/7/55</u> SIGNATURE <u>R. L. Richardson</u> ADDRESS (Street, city, town, state) <u>1100 Clay St Annapolis Md.</u> DATE SIGNED <u>7/7/55</u> M.D. <u>1100 Clay St Annapolis Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		LOCATION (city, town, or county) (State) <u>West St. -Annapolis, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>July 8, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ethel L. Hicks-45 Northwest St. -Annapolis Md.</u>			

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6241

CERTIFICATE OF DEATH

Reg. Dist. No. 06244 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		STATE Maryland		COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Crownsville		1yr. 6mos. 25 days.		TOWN Sparks		03X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
10 Crownsville State Hospital				None listed			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Hezekiah Stewart				7 18 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	Negro	Married	17-13-1881	67 yrs.	Months - Days -	Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None listed				Labor Farm - -		Virginia	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Thomas Stewart				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		Unk.		Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
Bronchopneumonia						4 days	
ANTECEDENT CAUSE(S) DUE TO						Known to us	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						since 12/23/53	
STATING UNDERLYING CAUSE LAST. DUE TO (B)							
Arteriosclerotic Hypertensive Cardiovascular Dis.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						Known to us since 12/23/53	
Senile Psychosis							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
- - - -		- - - - -					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> M. et work et work		21f. HOW DID INJURY OCCUR?			
- - - - -		- - - - -		- - - - -			
22. I hereby certify that I attended the deceased from 1/5, 19 55, to 7/18, 19 65, that I last saw the deceased alive on 7/17, 19 55, and that death occurred 8:15a. M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Hildegard K. K. Reim M.D.				Crownsville, Md.		7/18/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
7/21/55		Stephenson A. M. E.		Sparks		Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
7-20-55		1/17/55		Brooklyn Funeral Service, Sparks, Md.		J. Scott Brook	

CERTIFICATE OF DEATH

(58)

1. NAME OF DEATH		2. SEX		3. AGE	
JAMES G. GORDON		Male		38	
4. PLACE OF BIRTH		5. OCCUPATION		6. CAUSE OF DEATH	
Baltimore, Md.		Physician		Heart Disease	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
July 22, 1955		10:30 AM		Home	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF DEATH REGISTRAR	
[Signature]		[Signature]		[Signature]	

BUREAU - V. 2

JUL - 22 1955

RECEIVED

NOTICE: This certificate is valid only if it is filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within the time specified in the instructions to the Registrar.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06245

6242

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>D.C.</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>North Beach Park</i>		LENGTH OF STAY (in this place) <i>3 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>WASHINGTON</i>		<i>47X-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location) <i>6353-31ST ST. N.W</i>		✓	
3. NAME OF DECEASED (Type or Print) <i>MARGUERITE KIRK SWARTZ</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>JULY 2 1955</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>MAY 7, 1878</i>	9. AGE last birthday <i>77</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		11. BIRTHPLACE (State or foreign country) <i>AKRON, OHIO</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>JAMES KIRK</i>				14. MOTHER'S MAIDEN NAME <i>CHARLOTTE ?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, of unk.) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT & ADDRESS <i>JOHN C. SWARTZ NORTH BEACH PARK, MD</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						15. MEDICAL CERTIFICATION	
154X IMMEDIATE CAUSE (A) <i>Anemia</i>						INTERVAL BETWEEN ONSET AND DEATH <i>??</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Congestive Cardiac Failure</i>						<i>immediate</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Carcinoma of Rectum</i>						<i>15 years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>C Metastasis to spine</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Discovered</i> 19 <i>Not seen by me</i> to <i>Discovered</i> 19 <i>Not seen by me</i> that I last saw the deceased alive on <i>Discovered</i> 19 <i>Not seen by me</i> and that death occurred at <i>Discovered</i> M, from the causes and on the date stated above.							
SIGNATURE <i>H. Hendrichs</i>		DATE THEREOF <i>JULY 2, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>GLENDALE CEM.</i>		LOCATION (City, town, or county) (State) <i>AKRON OHIO</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL-TRANSIT</i>		24. REC'D BY REGISTRAR <i>John West Williams</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pamphrey</i>		ADDRESS <i>Bethesda, Md</i>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06246

6243

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A. Co.</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>A.A. Co.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HARWOOD</u>				TOWN <u>HARWOOD</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>DELIA ESTELLA THOMAS</u>				<u>7 10th 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>Colored</u>	<u>W</u>	<u>6-17-1888</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>---</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Philip Chambers</u>				<u>Lorenia Garrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>unk.</u>		<u>---</u>		<u>Viola Sterrett, Harwood, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
199.1 IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>199.1</u>				<u>8 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>none</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 10, 1955</u> , to <u>July 10, 1955</u> , that I last saw the deceased alive on <u>7/10</u> , 19 <u>55</u> , and that death occurred at <u>12:00 P.</u> M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Therese E. Johnson M.D. 37 Calvert St., Annapolis, Md</u>				<u>July 10, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-13-55</u>		<u>Chew Chapel</u>		<u>Owensville Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Edward Callinan</u>		<u>William Reese II, 108 W. Wash. St</u>			
DATE <u>July 14, 1955</u>				<u>ANNAPOLIS, Md</u>			

CERTIFICATE OF DEATH

Married A.A.C.
Shirleywood

A.A.C.
Shirleywood

Thomas
2-17-1982
MAYLAND
Lorena Garrett
Violet Street Harold, MD

Delia Estelle
W
2-17-1982
MAYLAND
Philip Chambers
Violet Street Harold, MD

BUREAU V. 3

JUL 14 1985

RECEIVED

Formal 12-13-82 Chew Chapel
William Rogers
12-13-82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6244
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
X TOWN <u>Severna Park</u>		<u>6 yrs.</u>		TOWN <u>Severna Park</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Manhattan Beach</u>				STREET ADDRESS (If rural, give location) <u>Manhattan Beach</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print) <u>LESLIE</u>		<u>MORTIMER</u>		<u>THOMPSON</u>		<u>7 11 19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>		<u>2/29/98</u>	<u>57</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>Rochester, New York</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Albert Tefft Thompson</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
Yes <input checked="" type="checkbox"/> (If Yes, give war or dates of service) <u>World War I</u>				<u>Ted Thompson (son)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>581.0</u>							
Immediate cause (a)..... <u>Massive gastro-intestinal hemorrhage</u>							
DUE TO							
Antecedent cause(s) (b)..... <u>rupture of esophageal varix</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)..... <u>cirrhosis of the liver</u>							
DUE TO							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
<u>7</u>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Wm. J. DeAlba</u>		<u>7/15/55</u>		<u>Riverside Cemetery</u>		<u>Rochester, New York</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE REC'D BY LOCAL REG.		REGISTER'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>BURIAL</u>		<u>July 13, 1955</u>		<u>L. J. DeAlba</u>		<u>Hopping and Kirkley, Glen Burnie, Md.</u>	

BUREAU

JUL 17

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06248

6245

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore City</u>		CITY <u>Baltimore City</u>		CITY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Crownsville</u>		<u>12 yrs. 2 mos. 18 days</u>		TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>918 Jordan Alley</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Joseph Tucker</u>				<u>7 5 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Negro</u>	<u>Sep.</u>	<u>2/28/02</u>	<u>53</u> yrs.	Months <u>-</u> Days <u>-</u>	Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Laborer</u>			<u>Unknown</u>		<u>Virginia</u>		<u>U. S.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Ralph Young</u>				<u>Mary Tucker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Known to us since 4/28/55</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Known to us since 4/13/33			
<u>Schizophrenic Reaction, Paranoid Type.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>8</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/21</u> , 19 <u>48</u> , to <u>7/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/5</u> , 19 <u>55</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict</u>		DATE SIGNED <u>7/5/55</u>		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>7/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>School Street Medical</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>R. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>578 W. Biddle St.</u>		ADDRESS <u>578 W. Biddle St.</u>	
DATE <u>7-6-55</u>							

MARTIN LUTHER KING, JR.

CERTIFICATE OF DEATH

MARTIN LUTHER KING, JR. STATE OF MISSISSIPPI - BIRMINGHAM, ALA.

NAME OF DECEASED MARTIN LUTHER KING, JR.		DATE OF DEATH APRIL 4, 1968	
PLACE OF DEATH MEMPHIS, TENNESSEE		TIME OF DEATH 4:05 PM	
CAUSE OF DEATH ASSAULT BY FIRE		MANNER OF DEATH ACCIDENTAL	
PLACE OF BIRTH ATLANTA, GEORGIA		AGE 39 YEARS	
OCCUPATION MINISTER OF THE GOSPEL		SEX MALE	
MARITAL STATUS SINGLE		RACE NEGRO	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	

BUREAU V. 8

JUL 11 1955

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MISSISSIPPI DEPARTMENT OF HEALTH AND HUMAN SERVICES. IT IS NOT VALID FOR THE PURPOSES OF THE MISSISSIPPI DEPARTMENT OF REVENUE.

06250

6174

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Q. A.</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Q. A.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>10 Annapolis</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 A. J. General</u>		STREET ADDRESS (If rural give location) <u>51 Franklin</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Helen</u> (Middle) <u>M. van Walt</u> (Last)		(Month) <u>7</u> (Day) <u>19</u> (Year) <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>4-16-1892</u>
9. AGE last birthday <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ernest Fowles</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Dr. Harry P. van Walt</u> (2)	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Sept Ventricular Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5 July, 1955</u> , to <u>19 July 1955</u> , that I last saw the deceased alive on <u>19 July, 1955</u> , and that death occurred at <u>8:05</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Harold S. Beck</u> M.D.		DATE SIGNED <u>7/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-22-55</u>	
24. REC'D BY REGISTRAR <u>John M. Taylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>	
DATE <u>7/22/55</u>		ADDRESS (Street, city, town, state) <u>Annapolis Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

THE DEATH OF

IN THE COUNTY OF

DECEASED

ON

AT

IN

OF

BY

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURIAL

PLACE OF REBURIAL

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURIAL

PLACE OF REBURIAL

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

CHARTERED BY

RECEIVED

BUREAU N. 8

JUL 25 1955

RECEIVED

6246

MARYLAND STATE DEPARTMENT OF HEALTH

06251

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH - COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) P.O. Pasadena		CITY (If outside corporate limits, write RURAL and give nearest town) Washington	
TOWN High Point.		TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Woods near Grammar School of High Point.		STREET ADDRESS (If rural, give location) 954 Southern Ave. S.E.	
3. NAME OF DECEASED (First) Francis (Middle) Donald (Last) Viering		4. DATE OF DEATH (Month) July (Day) 19 (Year) 1955	
5. SEX Male		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 3/4/24	
9. AGE last birthday 31 yrs.		10. If under 1 year Months 1 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lieutenant in the U.S. Air Forces.		11. BIRTHPLACE (State or foreign country) Neptune City, N.J.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward O Viering	
14. MOTHER'S MAIDEN NAME Eugenia ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes, Presently in the U.S. Air Forces.	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS U.S. Air Forces Records. (Captain J.R. Finn.)	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Charred and mutilated beyond recognition.		Sudden	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
19. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) In the air (CITY OR TOWN) High Point, P.O. Pasadena, A.A. Maryland. (COUNTY) 2 (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY 7/19/55 12.30 P.m.		INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? Collision in the air.	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE Kristine P. ...		DEGREE OR TITLE Deputy Medical Examiner.	
ADDRESS Glen Burnie, Md.		DATE SIGNED 7/20/55	
23. RURAL CREMATION RECORD (Specify)		DATE THEREOF 21 July 1955	
NAME OF CEMETERY OR CREMATORY Fort Lauderdale Florida		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. July 20, 1955		REGISTRAR'S SIGNATURE R. D. Alba	
24. FUNERAL DIRECTOR Ronald E. ...		ADDRESS 816-H St NE, Wash. D.C.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

JUL 22 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>B. & C. Co.</u>		MARYLAND		STATE <u>md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR		TOWN	
TOWN <u>Baltimore</u>		<u>1 mo.</u>		TOWN <u>Baltimore</u>		<u>3rd 14</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>G. G. Leiden. Sharp</u>				STREET ADDRESS (If rural, give location) <u>1629 G. Milton av</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<u>hours</u>		<u>Viktor</u>		<u>7 22 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>M.</u>	<u>W</u>	<u>M</u>	<u>June 1890</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>Balto. md.</u>			
13. FATHER'S NAME: <u>Joseph Viktor</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Kapralech</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>yes</u>		<u>212-20-9356</u>		<u>Lellean S. Viktor</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>4343</u>						<u>Seiden</u>	
Immediate cause (a) <u>Cardiac disease</u>							
DUE TO							
Antecedent cause(s) (b)							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>D</u>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>M.</u>		<u>work</u>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>Open hall</u>						<u>7/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>7-26-55</u>		<u>Holy Redeemer</u>		<u>Balto md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>25-55</u>		<u>W. J. W. W. W.</u>		<u>Mr. Brockman 9004 Chelton</u>			

6175

06252

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

6247

CERTIFICATE OF DEATH

8 : film G184 8-3-55 L

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Michigan</u>		COUNTY <u>Saginaw</u>	
CITY OR TOWN <u>Port George G. Meade</u>		LENGTH OF STAY (in this place) <u>3 1/2 Yrs.</u>		CITY OR TOWN <u>Saginaw</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>MARION W WALKER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 22 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>November 18, 1917</u>	9. AGE last birthday <u>43</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harold Rabe</u>				14. MOTHER'S MAIDEN NAME <u>Laura- maiden name unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Husband Colonel George Walker, Qtrs 4511, Port George G. Meade, Maryland</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
IMMEDIATE CAUSE (A) <u>CARCINOMA of BREAST with metastases</u>				6 1/2 months			
ANTECEDENT CAUSE(S) DUE TO (B) <u>and bilateral pleural effusion</u>				exact time unknown			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10 July, 19 55</u> , to <u>22 July, 19 55</u> , that I last saw the deceased alive on <u>21 July, 19 55</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John F. McDonnell, Jr.</u>		M.D. <u>Port George G. Meade, Md.</u>		DATE SIGNED <u>22 July 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-25-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		LOCATION (City, town, or county) (State) <u>Virginia</u>	
24. REC'D BY REGISTRAR <u>WILLIAM T. TAYLOR, 1ST LT</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>TAYLOR'S FUNERAL HOME, Annapolis, Md.</u>		ADDRESS			
DATE <u>22 July 1955</u>							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

240707ZUN73M
UNCLAS
FM JCRC
TO: JCRC
INFO: JCRC
SUBJECT: 240707ZUN73M
UNCLAS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6178

CERTIFICATE OF DEATH

06253

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSONVILLE, MD-X</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 A.A. GENERAL Hospt.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CHARLES</u> (Middle) <u>ST. CLAIR</u> (Last) <u>WAYSON JR.</u>				(Month) <u>7</u> (Day) <u>23</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3/27/1907</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TOBACCO</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES ST. CLAIR WAYSON SR.</u>				14. MOTHER'S MAIDEN NAME <u>AGNES TRABAUD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>VIRGINIA WAYSON #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>47 hr</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>48</u> , to <u>July 23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>55</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. B. ...</u>				ADDRESS (Street, city, town, state) <u>Annapolis MD</u>		DATE SIGNED <u>7/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7/25/55</u>		NAME OF CEMETERY OR CREMATORY <u>ALT HAWTHORNS</u>		LOCATION (City, town, or county) (State) <u>DAVIDSONVILLE MD</u>	
24. REC'D BY REGISTRAR <u>JOHN M. ...</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. ...</u>		ADDRESS <u>Annapolis, MD</u>	
DATE <u>7-26-55</u>							

CERTIFICATE OF DEATH

6179

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. MEDICAL CERTIFICATION

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF BURIAL PLACE

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF CLERK

22. SIGNATURE OF RECORDS

23. SIGNATURE OF ARCHIVES

24. SIGNATURE OF LIBRARY

25. SIGNATURE OF MUSEUM

26. SIGNATURE OF GALLERY

27. SIGNATURE OF THEATRE

28. SIGNATURE OF CIRCUS

BUREAU V. S.

JUL 27 1955

RECEIVED

[Handwritten signature]

6249 CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	A.A.		MARYLAND	STATE	Md
CITY (If outside corporate limits, write RURAL OR TOWN)	Brooklyn		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Brooklyn
HOSPITAL OR INSTITUTION OR STREET ADDRESS	5202 6th Street		STREET ADDRESS	5202 6th Street	
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year) OF DEATH:		
ROBERT H. WESTGATE			7/12/55 19		
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR
M	W	M	3/20/90	65 yrs.	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Mechanic		Slogles Serv. St.		Pa.	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
James			Helen Pickering		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
No		I96 03 0170		Family - Same	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					Jan 53-7-55
IMMEDIATE CAUSE					
(A) Coronary infarction					
DUE TO					
ANTECEDENT CAUSE (S)					
(B) coronary sclerosis					
DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 53, 1953, to Jan 7, 1955, that I last saw the deceased alive on 1-4-55, 1955, and that death occurred at 11:30 M, from the causes and on the date stated above.					
SIGNATURE		M. D.		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
B		7/16/55		Glen Haven	
24. FUNERAL DIRECTOR		ADDRESS		24. FUNERAL DIRECTOR	
James L. McCully - 130 E. Fort Ave.		James L. McCully - 130 E. Fort Ave.		James L. McCully - 130 E. Fort Ave.	

J. Summers.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06255 WC

6249

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		STATE MARYLAND		STATE Maryland		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Crownsville		2 yrs. 29 days		TOWN Baltimore City		3001-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) 921 Stricker Street			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Maude Wilson				7 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	Negro	Widow	Unknown	54 yrs.	Months — Days —	Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None		— — —		Maryland		U. S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Thomas Brown				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		Unk.		Hospital Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2 days	
443X IMMEDIATE CAUSE (A)							
Heart Failure							
ANTECEDENT CAUSE(S) DUE TO (B)							
Hypertensive Cardiovascular disease						2 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						2 yrs	
arteriosclerosis with myocardial infarction							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
— — — —		— — — —					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
— — — —		— — — —		— — — —			
22. I hereby certify that I attended the deceased from <u>1/5</u>, 19<u>55</u>, to <u>7/19</u>, 19<u>55</u>, that I last saw the deceased alive on <u>7/18</u>, 19<u>55</u>, and that death occurred at <u>4:30a</u> M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Heard Reine				Crownsville, Md.		7/19/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		7/25/55		Mt. Calvary Cem.		A. A. County, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 7-22-55		Maureen M. Joyce		Mrs. Robt. A. Ellish		1501 N. ...	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

<p>NAME: <i>Wilson</i></p> <p>AGE: <i>7</i></p> <p>SEX: <i>Male</i></p> <p>RACE: <i>White</i></p> <p>DATE OF BIRTH: <i>Jan 1, 1948</i></p> <p>PLACE OF BIRTH: <i>St. Louis, Mo.</i></p> <p>EDUCATION: <i>High School</i></p> <p>OCCUPATION: <i>Student</i></p> <p>RESIDENCE: <i>921 Jackson St. Baltimore, Md.</i></p>	<p>DATE OF DEATH: <i>Aug 1, 1955</i></p> <p>PLACE OF DEATH: <i>Home</i></p> <p>CAUSE OF DEATH: <i>Heart Failure</i></p> <p>IMMEDIATE CAUSE: <i>Myocardial Infarction</i></p> <p>UNDERLYING CAUSE: <i>Coronary Artery Disease</i></p> <p>PERMANENT CAUSE: <i>Coronary Artery Disease</i></p> <p>INTERPRETER: <i>Dr. J. H. Smith</i></p> <p>DATE OF INTERVIEW: <i>Aug 1, 1955</i></p> <p>SIGNATURE: <i>[Signature]</i></p>
--	--

Heart Failure
 Myocardial Infarction
 Coronary Artery Disease
 (e) arteriosclerosis/hypertension
 8 yrs
 8 yrs
 8 yrs

BUREAU V. 8

JUL 22 1955

RECEIVED

#123 and #12345
 7/27/55

ENCLOSURE